

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 13001		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		69 13001	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) ANTHONY C. ZWINGLE		2. DATE AND HOUR OF DEATH Dec 30 1969 9:30 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD CHURCH HOME & HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 201		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION CHURCH HOME & HOSPITAL		E. STREET AND NUMBER 320 S. Washington			
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-2-06	9. AGE (In years last birthday) 63	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLOTHING WORK		10B. KIND OF BUSINESS OR INDUSTRY CLOTHING		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ANTHONY ZWINGLE		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 213-09-9139		17. INFORMANT SOPHIA ZWINGLE 320 S. WASHINGTON ST.	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 410.9 I <small>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</small> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ACUTE MYO CARDIAL VENTRICULAR FIBRILLATION		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 H	
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). ARTERIOSCLEROTIC HEART DISEASE		19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Dec 30 19 69 to Dec 30 19 69 that (I) (we) last saw the deceased alive on Dec. 30 19 69 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE C. Vergara M.D.		23B. DATE SIGNED 12-30-69			
23C. PHYSICIAN'S NAME (Type) CORAZON Z. VERGARA, M.D.		23D. ADDRESS CHURCH HOME & HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1-3-70		24C. NAME OF CEMETERY or CREMATORY HOLY ROSARY CEMETERY	
24D. LOCATION (City, town, or county) (State) DUNDALK MARYLAND		25A. DATE REC'D BY HEALTH DEPT. JAN 2 1970		25B. NAME OF REGISTRAR E. Talley, M.D.	
25C. FUNERAL DIRECTOR JOHN M. WEBERSON'S INC 401 S. CHESTER ST.					

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69 13002

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO.

69 13002

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

LOMAN, Poling

2. DATE AND HOUR OF DEATH

12-29-69

2 00 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Baltimore City Hospitals

4940 Eastern Avenue

Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

1040 Quantrill Way

21205

5. SEX

Male

6. RACE

White

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☒

8. DATE OF BIRTH

5-17-1912

9. AGE (in years
last birthday)

57

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Carpenter

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

West Virginia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Arthur A.

14. MOTHER'S MAIDEN NAME

Myra ~~Shove~~ Fincham15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

269-12-6523

17. INFORMANT

ADDRESS

Records: BCH-4940 Eastern Avenue 21224

18. 52181

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Hepatic insufficiency

10 yrs.

(B) DUE TO, OR AS A CONSEQUENCE OF:

Bleeding esophageal varices

(C) DUE TO, OR AS A CONSEQUENCE OF:

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

Acute Renal Failure

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION

WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?
(If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 10-27-69 19 to 12-29 1969
that (I) (we) last saw the deceased alive on 12-29 1969 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Kenneth C. Gertsen, M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☐

23B. DATE SIGNED

12-29-1969

23C. PHYSICIAN'S
NAME (Type)

Kenneth Gertsen, M.D.

23D. ADDRESS

Baltimore City Hospitals 21224

4940 Eastern Avenue, Baltimore, Maryland

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

1-1-70

24C. NAME OF CEMETERY OR CREMATORY

Jurusalem Church Cemetery

24D. LOCATION

(City, town, or county)

(State)

Mill Creek, West Virginia

25A. DATE REC'D BY HEALTH DEPT.

JAN 2 1970

25B. NAME OF REGISTRAR

E. G. Gertsen, M.D.

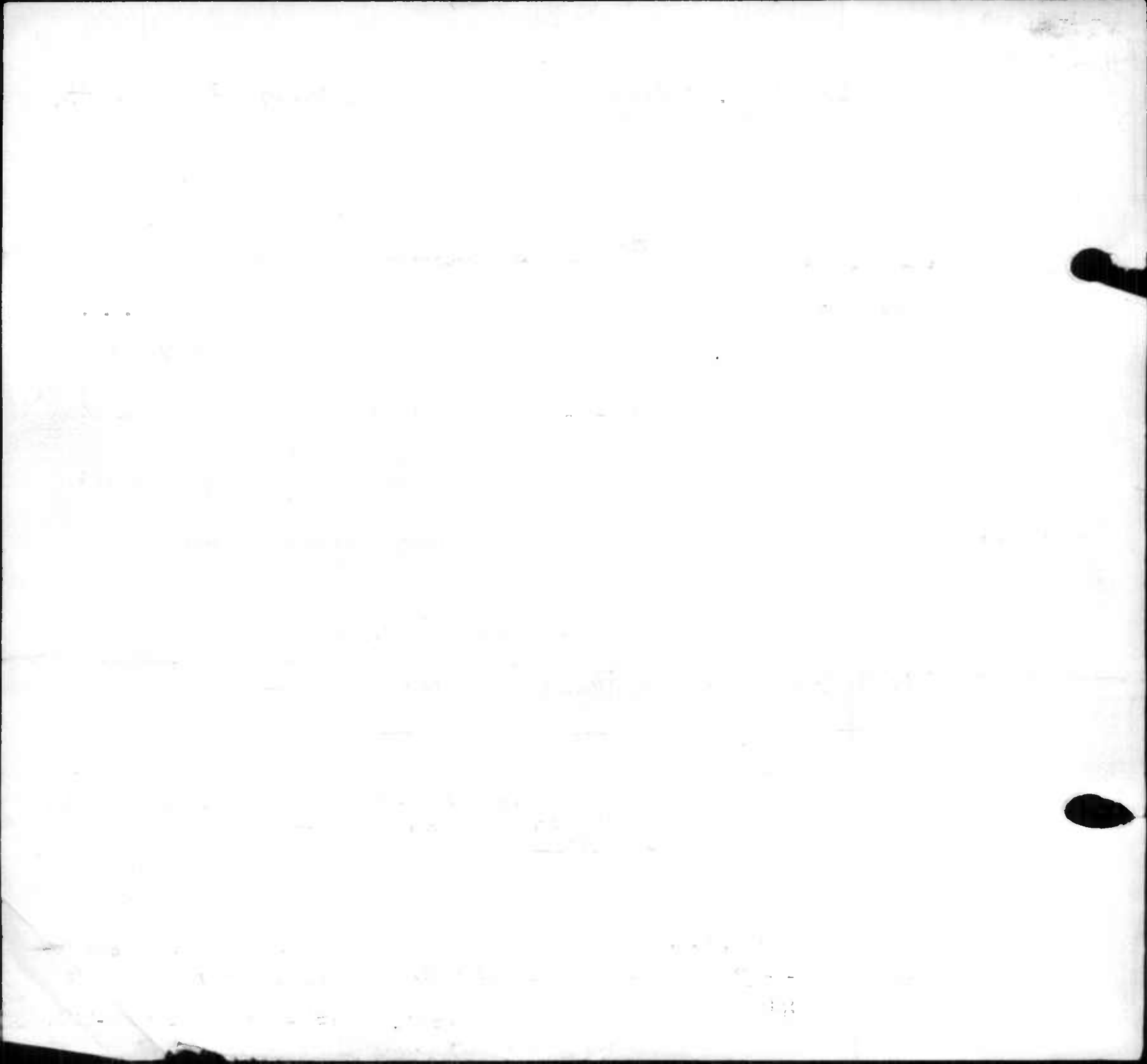
25C. FUNERAL DIRECTOR

Howard H. Hubbard - 4107 Wilkens Ave-21229

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

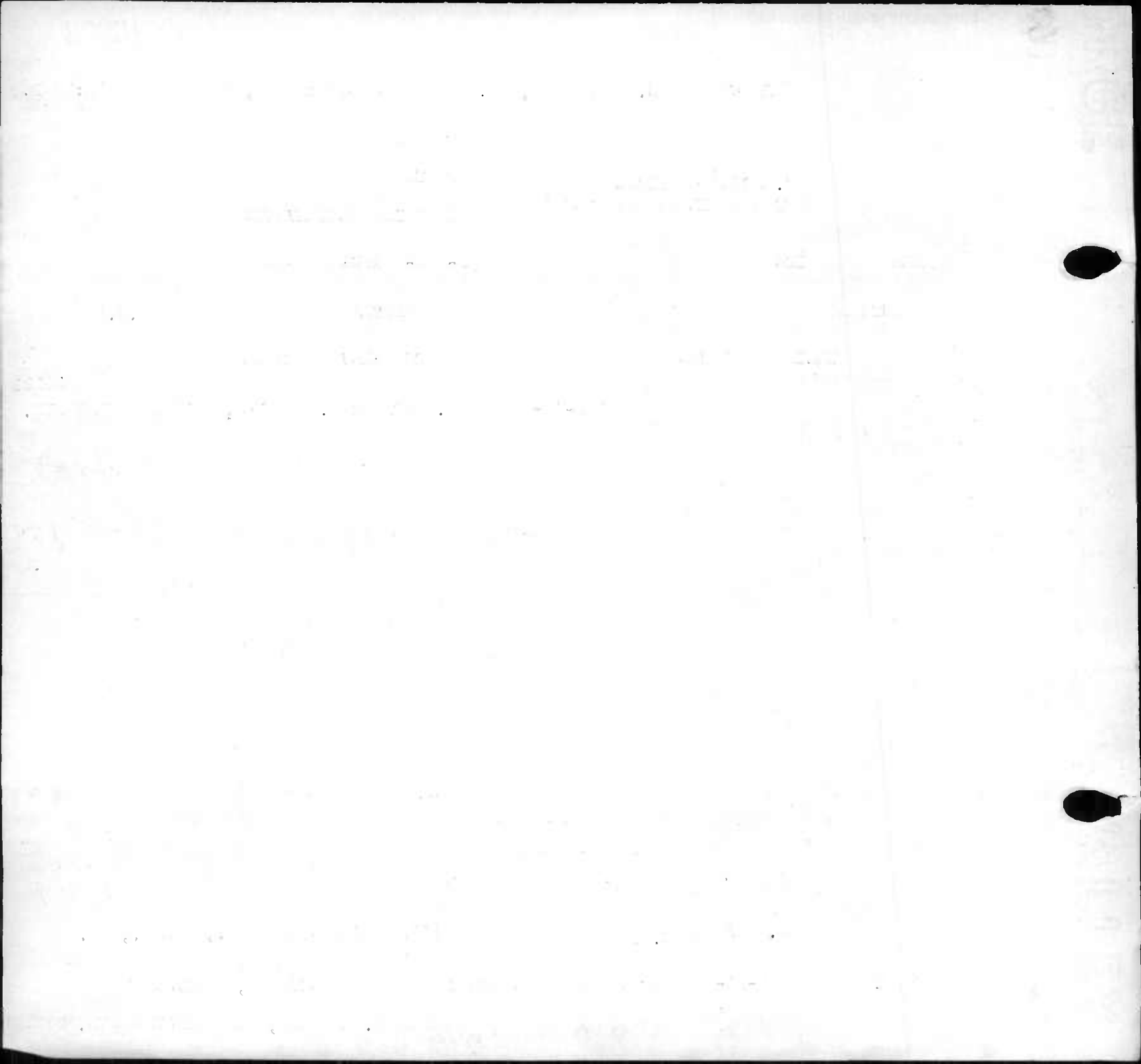
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



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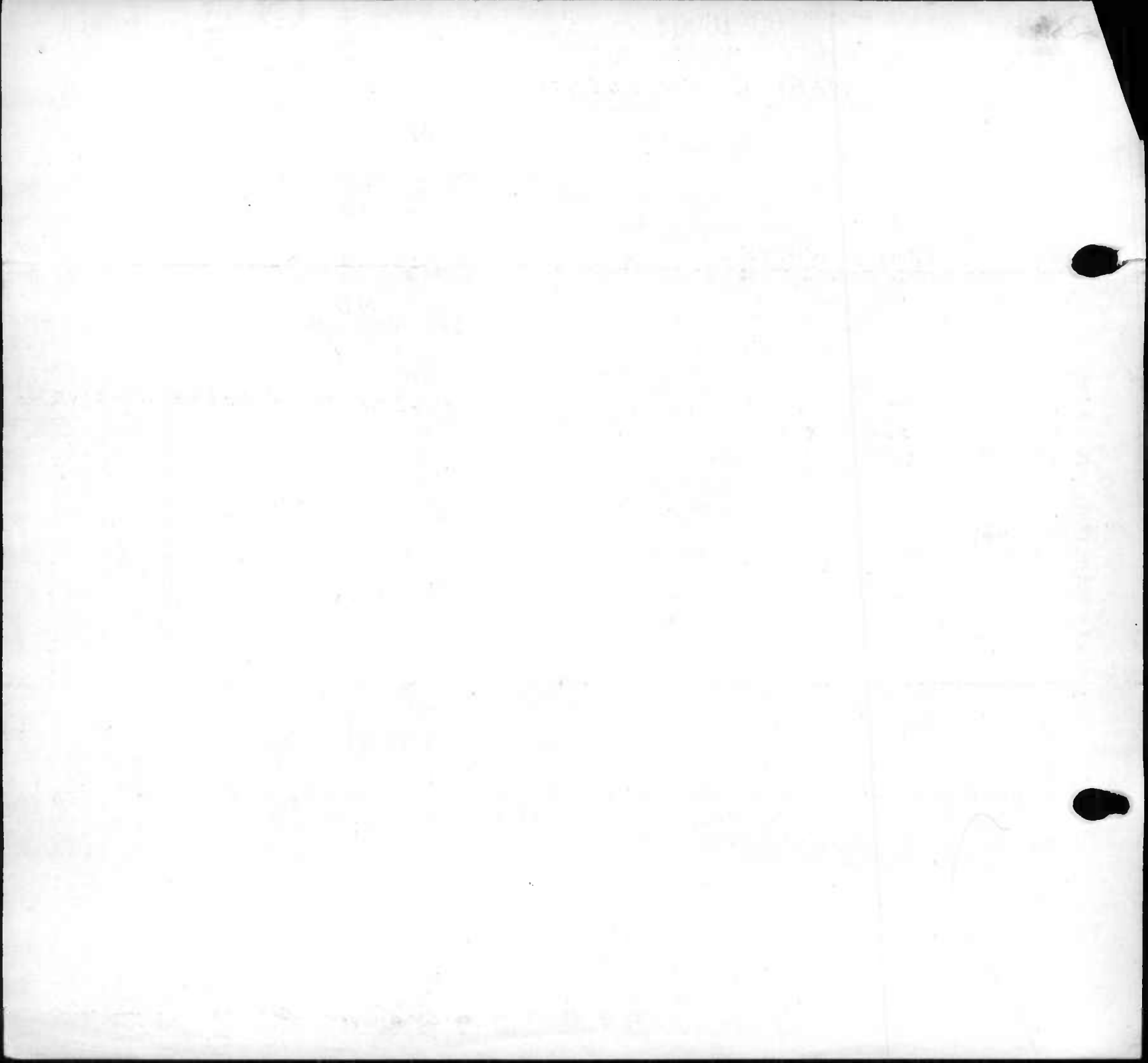
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 13003	
1. NAME OF DECEASED (Type or Print) JAMES C. SANDERS, SR.			2. DATE AND HOUR OF DEATH December 27, 1969 1:20 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL CATON & WILKENS AVENUES			A. STATE MARYLAND B. COUNTY 2582		
			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 1022 PARKSLEY AVENUE		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-4-1921	9. AGE (In years last birthday) 48	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BUTCHER		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME WILLIAM SANDERS			14. MOTHER'S MAIDEN NAME GENEVIEVE TOLLE		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 215-12-8787	17. INFORMANT ADDRESS MRS. MARGARET M. SANDERS, 1022 PARKSLEY AVE. 21223		
18. 41221 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral Hemorrhage 5 hrs (B) Hypertensive C.V.D. DUE TO, OR AS A CONSEQUENCE OF: 3-5 yrs (C) _____		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from March 1949 to Dec 27 1969 , that (I) (we) last saw the deceased alive on Dec 27 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE John C. Pound M.D.				23B. DATE SIGNED 12/29/69	
23C. PHYSICIAN'S NAME (Type) DR. JOHN C. POUND				23D. ADDRESS 3325 FREDERICK AVE., BALTO., MD.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12-31-69		24C. NAME OF CEMETERY or CREMATORY LOUDON PARK CEMETERY	
				24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. JAN 2 1970		25B. NAME OF REGISTRAR R. E. Fisher, Jr.		25C. FUNERAL DIRECTOR ADDRESS HOWARD H. HUBBARD, 4107 WILKENS AVE. 21229	



FUNERAL DIRECTOR: IMPORTANT

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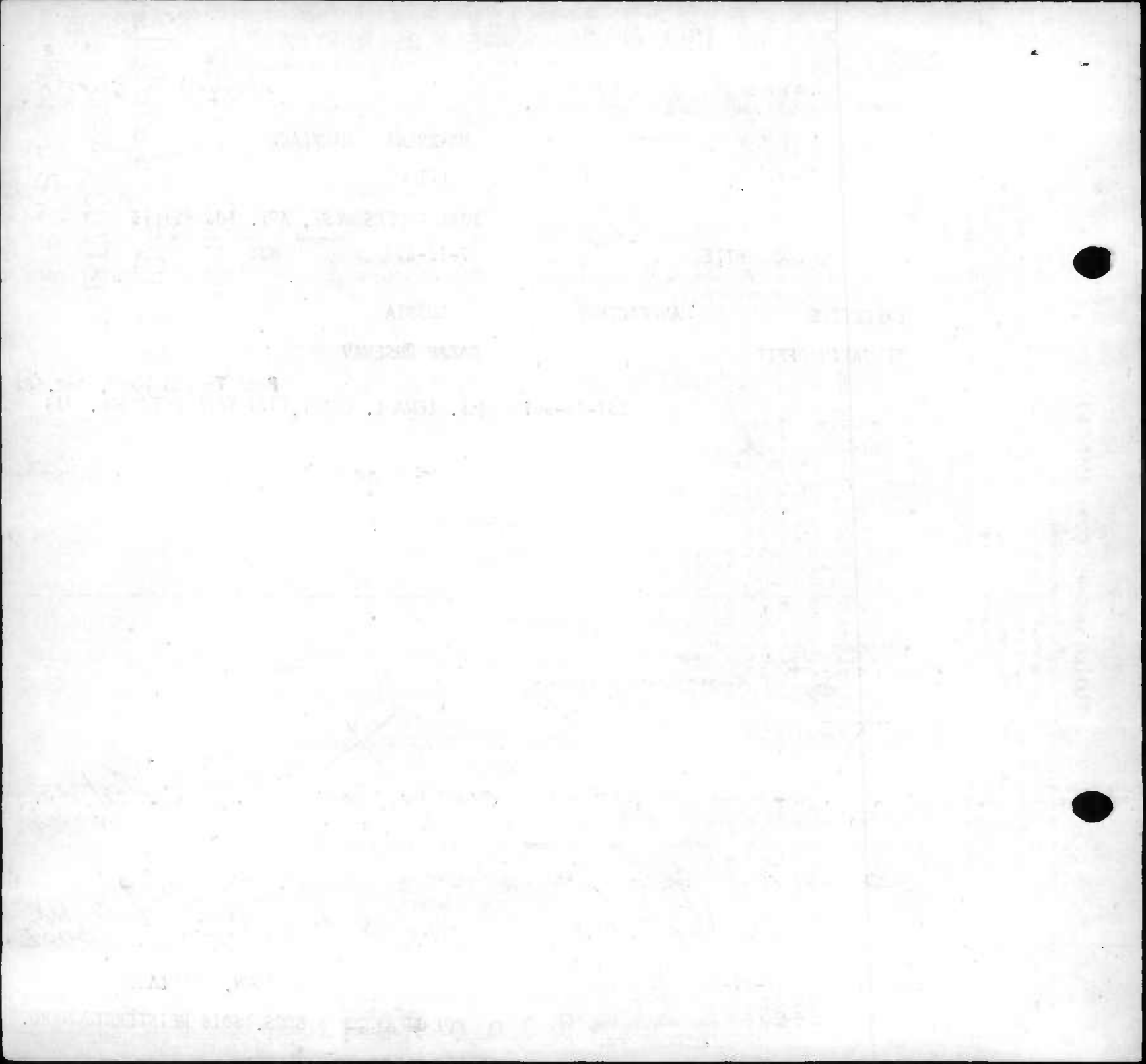
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 13004
69 13004		BIRTH NO. MARY POSEDENTI		
1. NAME OF DECEASED (Type or Print) MARY C. POSEDENTI		2. DATE AND HOUR OF DEATH 12-29-69 16:40 A. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE M B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION 46 LUTHERAN HOSPITAL of MARYLAND		C. CITY OR TOWN Balt. Md. 21211		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX FEMALE 6. RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-22-94 75
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ELIZABETH MANN 3123 CRITTENDEN PLACE
18. 403 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) NEPHROSCLEROSIS CHRONIC UREMIA		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) showing the UNDERLYING CONDITION lost.		(B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) —
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 12-23 19 69 to 12-29 19 69 , that (I) (we) last saw the deceased alive on 12-29 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Violet R. Gamarra R. M.D.				23B. DATE SIGNED 12-29-69
23C. PHYSICIAN'S NAME (Type) VIOLET R. GAMARRA R. M.D.		23D. ADDRESS 730 Ashburton St. Balt. Md.		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12-31-69		24C. NAME OF CEMETERY or CREMATORY NEW CATHEDRAL
24D. LOCATION (City, town, or county) (State) BALTO MD		25A. DATE REC'D BY HEALTH DEPT. JAN 2 1970		
25B. NAME OF REGISTRAR 224 E. Taylor, Md.		25C. FUNERAL DIRECTOR 3615 Chestnut Ave		



FUNERAL DIRECTOR: IMPORTANT

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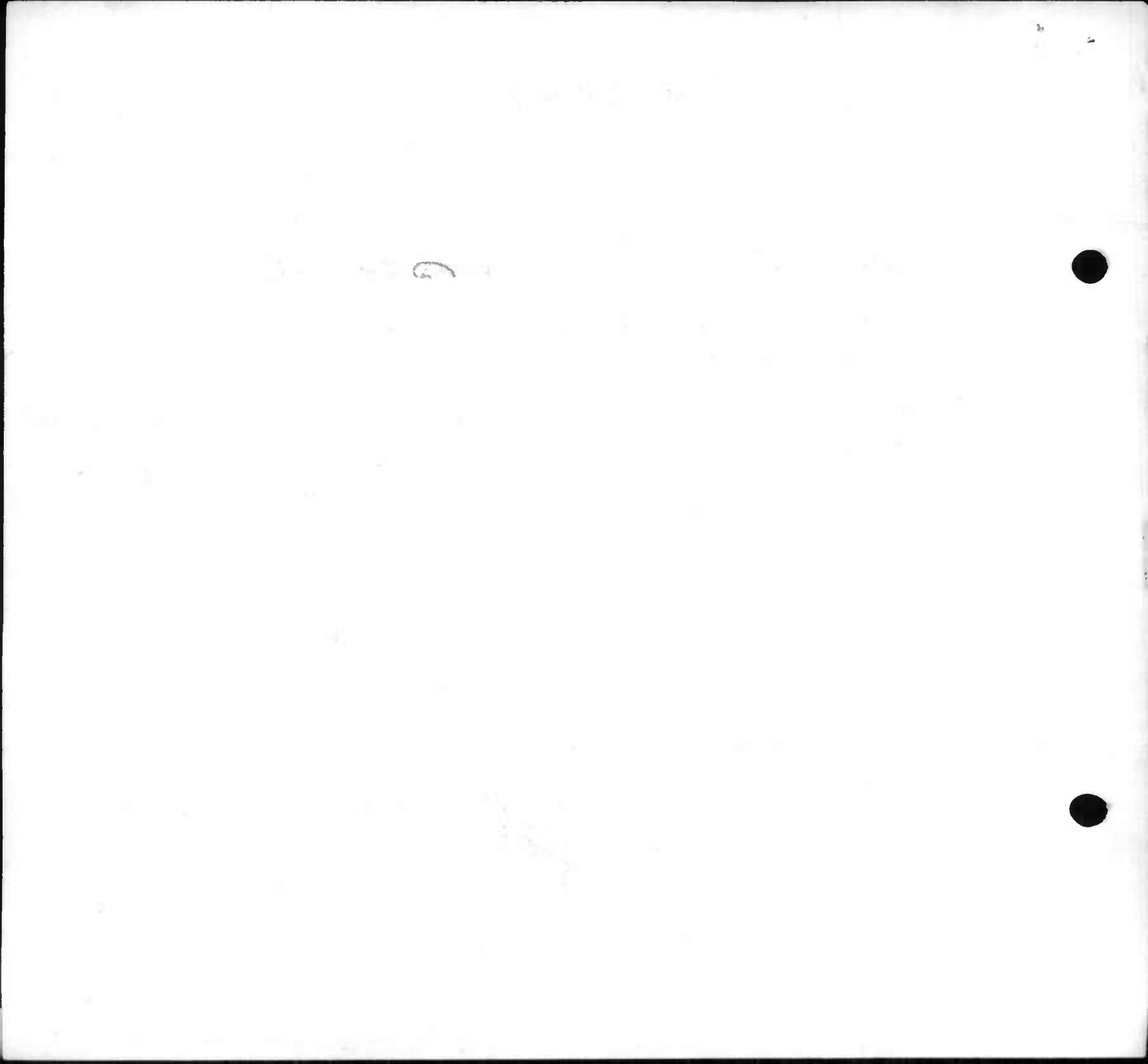
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 13005
BIRTH NO. 69 13005		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) Morris A. Offit		2. DATE AND HOUR OF DEATH 12/29/69 8:05 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 2730		
FULL NAME OF HOSPITAL OR INSTITUTION 00 (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 7121 Park Heights Ave - Apt 608 Baltimore, Md.		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER PARK TOWERS WEST, APT. 608 #21215		
5. SEX Male	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-12-89	9. AGE (In years last birthday) 80 If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) EXECUTIVE		10B. KIND OF BUSINESS OR INDUSTRY MANUFACTURE		11. BIRTHPLACE (State or foreign country) RUSSIA
12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME BENJAMIN OFFIT		14. MOTHER'S MAIDEN NAME SARAH ROSEMAN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 261-26-6985		17. INFORMANT Mrs. LENA L. OFFIT, 7121 PARK HGTS AVE. #15
18. 153.8 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE carcinomatosis DUE TO, OR AS A CONSEQUENCE OF Carcinoma of colon (B) over 3 months DUE TO, OR AS A CONSEQUENCE OF: (C) II		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION About 2 months ago		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Suspected carcinoma		20A. AUTOPSY? (Yes or No) No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input checked="" type="checkbox"/>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <input checked="" type="checkbox"/>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <input checked="" type="checkbox"/>
22. I certify that (I) (this hospital) attended the deceased from about 2 months ago to 12/29/1969 that (I) (we) last saw the deceased alive on 12/29/1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
23A. SIGNATURE Gennd N. Maggid, M.D.		23B. DATE SIGNED 12/29/69		
23C. PHYSICIAN'S NAME (Type) Gennd N. Maggid, M.D.		23D. ADDRESS Pikesville Medical Center Baltimore, Md. 21208		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-31-69		24C. NAME OF CEMETERY or CREMATORY BETH EL
24D. LOCATION (City, town, or county) RANDALLSTOWN, MARYLAND				
25A. DATE REC'D BY HEALTH DEPT. JAN 2 1970		25B. NAME OF REGISTRAR R. E. F. B. M. D.		25C. FUNERAL DIRECTOR LEVINSON
ADDRESS SP. & BROS. 6010 REISTERSTOWN RD.				



FUNERAL DIRECTOR: IMPORTANT

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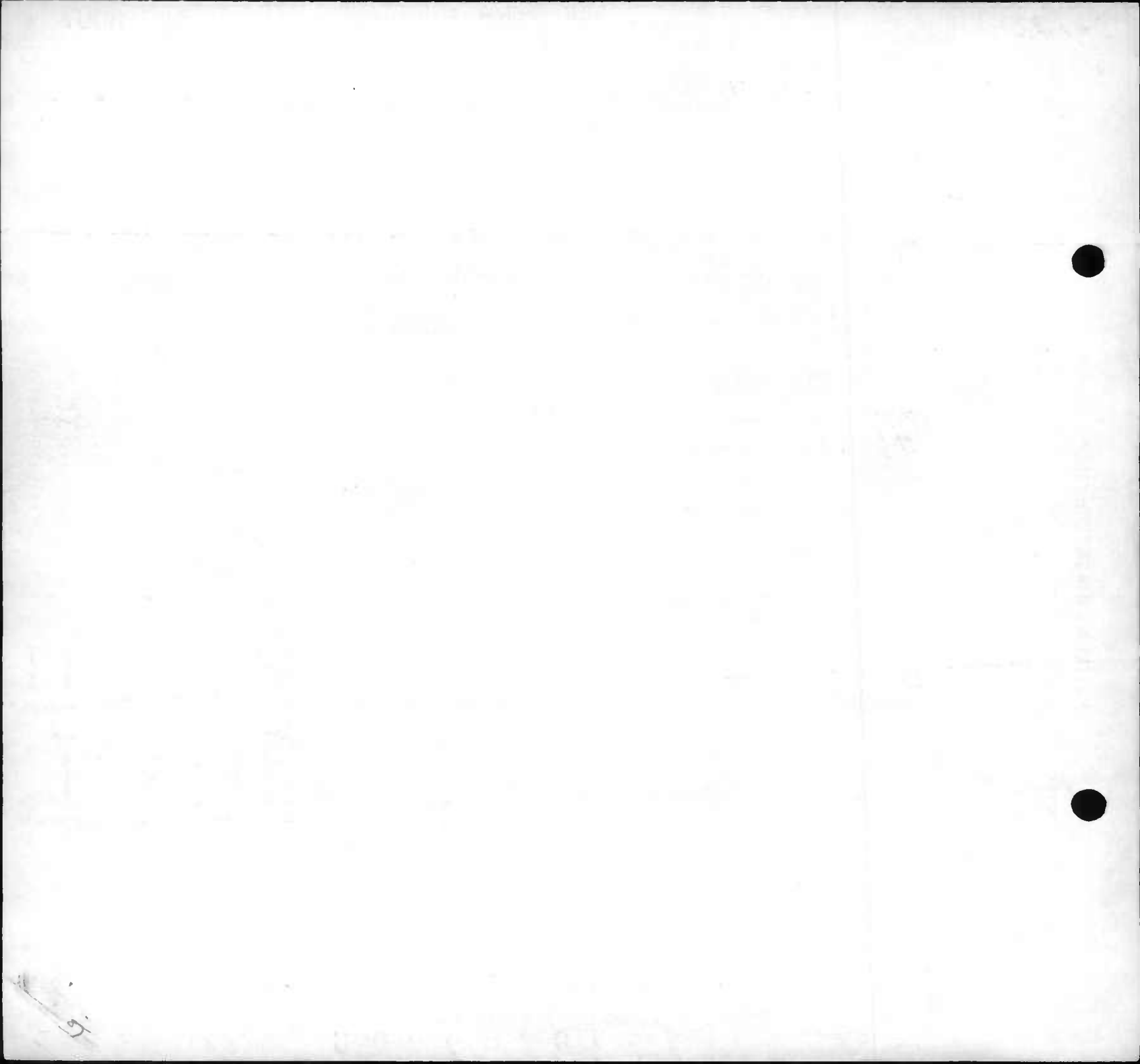
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 69 13006	
1. NAME OF DECEASED (Type or Print) LOUIS (MIZVINSKY) MEZVINSKY		2. DATE AND HOUR OF DEATH 12/30/68 3.30 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD SINAI HOSP.		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 2831			
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSP.		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 6612 EBERLE DR #A					
5. SEX MALE	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH [REDACTED]	9. AGE (In years last birthday) 80	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor		10B. KIND OF BUSINESS OR INDUSTRY Employee		11. BIRTHPLACE (State or foreign country) Russia	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 812-01-6258		17. INFORMANT Mrs. Marie Zaczek apt 203 #15	
18. 427.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CONGESTIVE HEART FAILURE		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CONGESTIVE HEART FAILURE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 Days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). PNEUMONIA					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/22/68 19 to 12/30/68 19 that (I) (we) last saw the deceased alive on 12/30/68 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE A. M. Verry M.D.		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12/30/68	
23C. PHYSICIAN'S NAME (Type) A. M. Verry M.D.		23D. ADDRESS Sinai Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-31-69		24C. NAME OF CEMETERY or CREMATORY Progressive Cemetery of Relief	
24D. LOCATION Maryland		24E. NAME OF REGISTRAR Bob E. Taylor, M.D.			
25A. DATE REC'D BY HEALTH DEPT. JAN 2 1970		25B. NAME OF REGISTRAR Bob E. Taylor, M.D.		25C. FUNERAL DIRECTOR 6010 ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 69 13007		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 69 13007	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) EARL W. DAVIS			2. DATE AND HOUR OF DEATH 12/27/69 5:37 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 48 MD. GENERAL HOSP.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY BALT. C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 2401 E. TAW PL.		
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 10/15/95	9. AGE (In years last birthday) 74	10. CITIZEN OF WHAT COUNTRY? USA
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown			10B. KIND OF BUSINESS OR INDUSTRY -		
11. FATHER'S NAME NATHANIEL DAVIS			12. MOTHER'S MAIDEN NAME LILLIE MAE ROSS		
13. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) unknown ?			14. SOCIAL SECURITY NO. 268-18-4907 A		
15. INFORMANT PREO. ADMISSION			ADDRESS		
16. CAUSE OF DEATH I 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH		
17. DATE OF OPERATION 0			18. CONDITION FOR WHICH OPERATION WAS PERFORMED		
19A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			19B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
20A. AUTOPSY? (Yes or No) NO			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21B. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21C. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21D. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 12/5/69 19 to 12/27/69 19 that (I) (we) last saw the deceased alive on 12/27 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE M. F. Whitworth			23B. DATE SIGNED 12/27/69		
23C. PHYSICIAN'S NAME (Type) M. F. WHITWORTH			23D. ADDRESS MD. GEN. HOSP		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/31/69		24C. NAME OF CEMETERY or CREMATORY Glen Haven Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. JAN 2 1970		25B. NAME OF REGISTRAR R. E. Taylor, M.D.	
25C. FUNERAL DIRECTOR John J. Cowan & Son		25D. ADDRESS 1099 E. Taw Pl.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
REG. NO. 69 13008

69 13008
CERTIFICATE OF DEATH

BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) Jacob Jacobs 2. DATE AND HOUR OF DEATH 12/27/69 12:05 PM

3. PLACE IN BALTIMORE MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Maryland B. COUNTY 2730

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Siwai Hospital C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES ☒ NO ☐

E. STREET AND NUMBER 3315 CLARKS LANE, APT. B

5. SEX MALE 6. RACE WHITE 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH 5/10/93 9. AGE (In years last birthday) 76 If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PROPRIETOR 10B. KIND OF BUSINESS OR INDUSTRY LEATHER 11. BIRTHPLACE (State or foreign country) Russia 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME ISAAC JACOBS 14. MOTHER'S MAIDEN NAME ANNA ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO 16. SOCIAL SECURITY NO. 218-32-2336 17. INFORMANT MRS. BESSIE JACOBS, 3315 CLARKS LANE, APT. B ADDRESS _____

18. 412.4 I CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE Gram Negative Sepsis
DUE TO, OR AS A CONSEQUENCE OF:
(B) Shock 2° to E. Coli U.T.I.
DUE TO, OR AS A CONSEQUENCE OF:
(C) A.S.C.U.D.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION 12/16 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____ 20A. AUTOPSY? (Yes or No) _____ 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) _____ 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) _____ 21E. INJURY OCCURRED _____ 21F. HOW DID INJURY OCCUR? _____

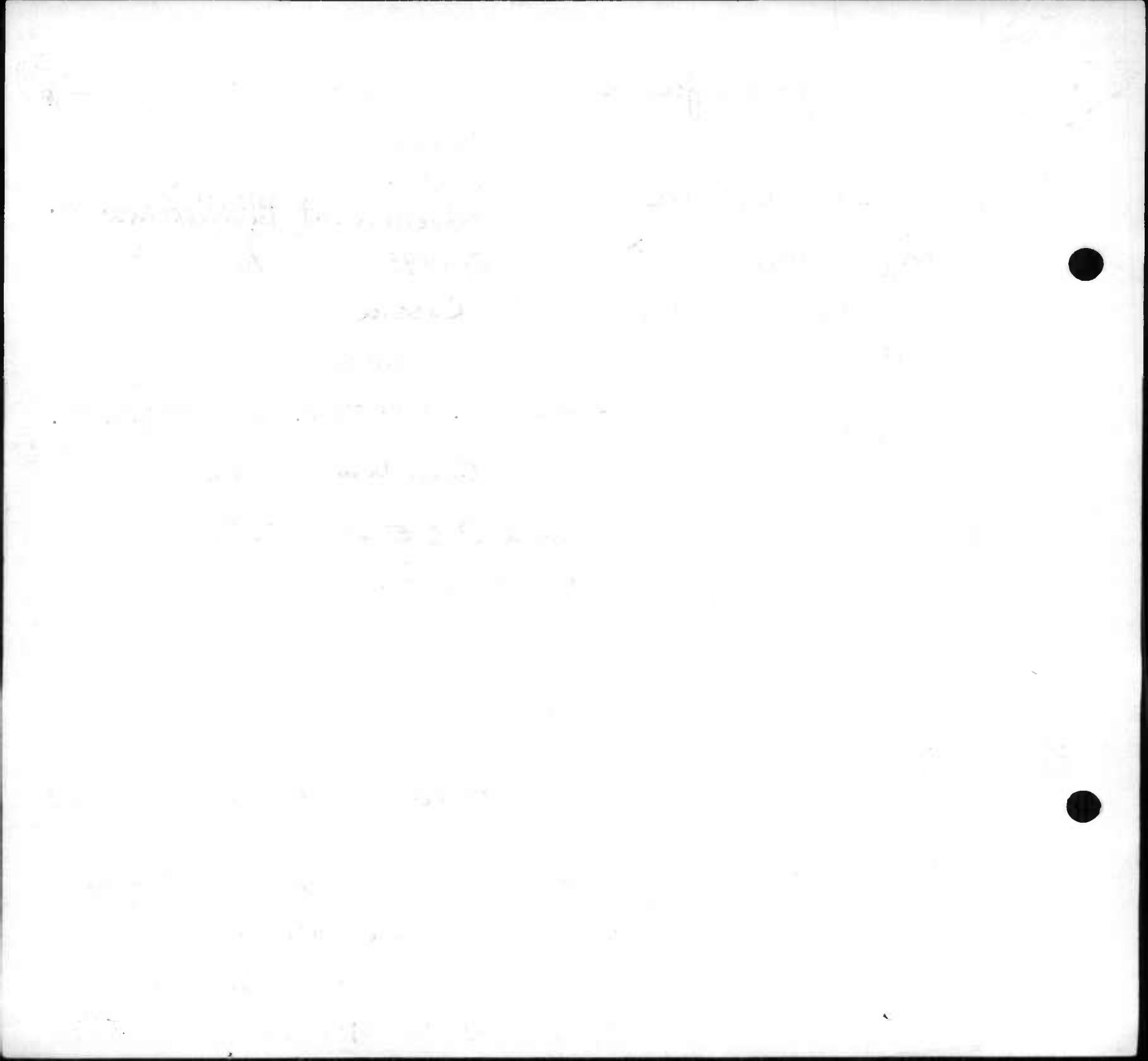
22. I certify that (I) (this hospital) attended the deceased from 12/16 1968 to 12/27 1968 that (I) (we) last saw the deceased alive on _____ 19_____ and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE Carlos R. Perel 23B. DATE SIGNED 12/27/69
Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23C. PHYSICIAN'S NAME (Type) Carlos R. Perel 23D. ADDRESS Siwai Hospital

24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL 24B. DATE 12/28/69 24C. NAME OF CEMETERY OR CREMATORY AIRY CHAM CONG 24D. LOCATION (City, town, or county) (State) WASHINGTON BLVD

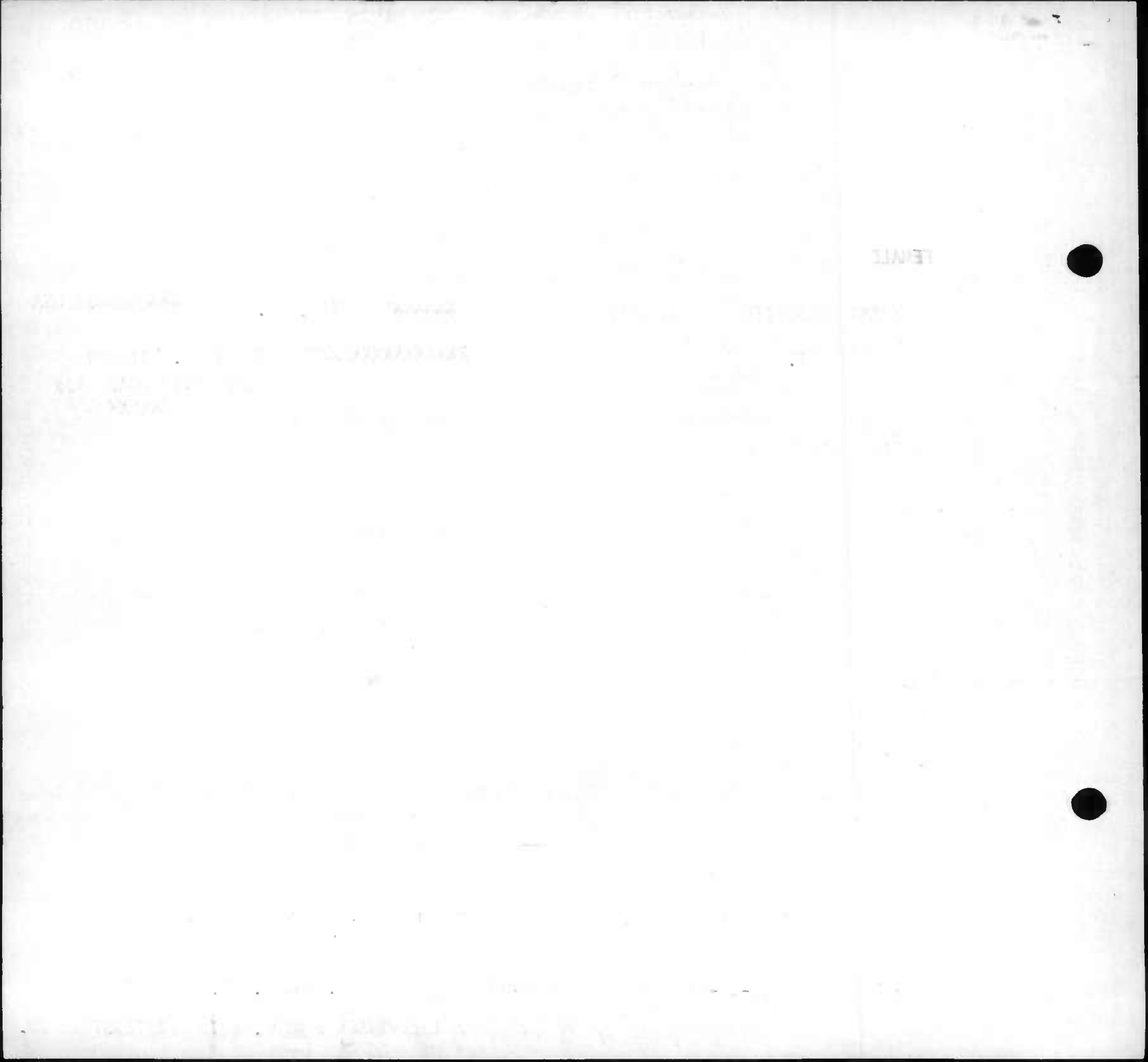
25A. DATE REC'D BY HEALTH DEPT. JAN 2 1970 25B. NAME OF REGISTRAR JOSE TABATA 25C. FUNERAL DIRECTOR SQL BERNARD & BROS ADDRESS 64170, MD



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 13009
BIRTH NO. 69 13009		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) Cohn, Pauline ROSENBERG		2. DATE AND HOUR OF DEATH 12/28/69 8:17am		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION The Union Memorial Hospital 38th Street		A. STATE Maryland B. COUNTY 2740		
C. CITY OR TOWN Baltimore 15		D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER 3409 Devonshire Rd				
5. SEX FEMALE	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 09-09-1957	9. AGE (In years last birthday) 12
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) PHILA, PA.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Abraham F. Rosenberg		
14. MOTHER'S MAIDEN NAME JENNIE W. WILFSON		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO.		17. INFORMANT M. Irving F. Cohn ADDRESS 8206 ANITA ROAD #08		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 412.21 I (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF: (B) Hypertension or ASCVD DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). low grade fever 41.0				
19A. DATE OF OPERATION 0	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) NO	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 12/16 19 69 to 12/18 19 69 , that (I) (we) last saw the deceased alive on 12/27 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Dr. Van Kamen		23B. DATE SIGNED 12/28/69		23C. PHYSICIAN'S NAME (Type or Print) DR. D. P. VAN KAMEN
23D. ADDRESS The Union Memorial Hospital				
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 12-29-69	24C. NAME OF CEMETERY OR CREMATORY HEBREW FRIENDSHIP	24D. LOCATION E. BALTO. ST.	24E. CITY, TOWN, OR COUNTY MARYLAND
25A. DATE REC'D BY HEALTH DEPT. JAN 2 1970		25B. NAME OF REGISTRAR Paul E. Zuber		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS. 6010 REISTERSTOWN RD.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 13010

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

69 13010

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Ansel Schoeneman

2. DATE AND HOUR OF DEATH

12-27-69 3¹⁰ P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

00 IMPERIAL APARTMENTS, APT. C

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE B. COUNTY

Maryland

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

Imperial Apts - Apt C, Clark Lane #15

5. SEX

MALE

6. RACE

WHITE

7. MARRIED ☐

NEVER MARRIED ☐

WIDOWED ☒

DIVORCED ☐

8. DATE OF BIRTH

12-27-79

9. AGE (In years last birthday)

90

If Under 1 Yr. Months Days

If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

RETIRED

10B. KIND OF BUSINESS OR INDUSTRY

MANUFACTURING

11. BIRTHPLACE (State or foreign country)

BALTIMORE, MARYLAND

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

JACOB SCHOENEMAN

14. MOTHER'S MAIDEN NAME

FANNIE WURTZBURGER

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

17. INFORMANT

MRS. JAY JEFFERSON MILLER, JEMICY FARM,

ADDRESS

PARK HEIGHTS AVE,

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

Constrictive Heart Failure - Acute Pulmonary Edema

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Hypertensive Arteriosclerotic Cardiovascular Disease

(B) DUE TO, OR AS A CONSEQUENCE OF:

Generalized Arteriosclerosis

(C) DUE TO, OR AS A CONSEQUENCE OF:

Memoria

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

3 days

10 years

25 years

1 day

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from November 10 1969 to December 27 1969, that (I) (we) last saw the deceased alive on December 27 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

H. William Primakoff

DEGREE

Attending Phys. ☒

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

December 27, 1969

23C. PHYSICIAN'S NAME (Type)

H. WILLIAM PRIMAKOFF

DEGREE

23D. ADDRESS

EMERSONIAN APTS. #2

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

12-29-69

24C. NAME OF CEMETERY or CREMATORY

BALTIMORE HEBREW

24D. LOCATION

(City, town, or county)

(State)

BELAIR ROAD, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.

JAN 2 1970

25B. NAME OF REGISTRAR

Robert E. Fager, R.D.

25C. FUNERAL DIRECTOR

SOL LEVINSON & BROS. 6010 REISTERSTOWN ROAD

ADDRESS

3601 Clark's La.

FOR APPROVAL

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 13011

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

69 13011

BIRTH NO.		1. NAME OF DECEASED (Type or Print) SHAPIRO, WILLIAM		2. DATE AND HOUR OF DEATH 12-27-69 1:15 PM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 42 SINAI HOSPITAL of BALTIMORE		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 2716		C. CITY OR TOWN BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL of BALTIMORE		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-11-85	9. AGE (In years last birthday) 84	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PROPRIETOR RETIRED		10B. KIND OF BUSINESS OR INDUSTRY GROCERY STORE		11. BIRTHPLACE (State or foreign country) RUSSIA	
13. FATHER'S NAME ZEV SHAPIRO		14. MOTHER'S MAIDEN NAME UNKNOWN		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT MR. SYLVAN SHAPIRO, 3405 A. COURTLIGH ROAD	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CONGESTIVE HEART FAILURE ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ARTERIOSCLEROTIC HEART DISEASE		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: INTERTROCHANTERIC H.P.F. (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 14 days	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). INTERTROCHANTERIC H.P.F.		19A. DATE OF OPERATION NONE		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) HOME		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 3404 Royce Ave	
21D. TIME OF INJURY (APPROX.) 12-12-69		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? FELL at HOME.	
22. I certify that (if this hospital) attended the deceased from 12-12-69 19 to 12-27-69 19 that (we) last saw the deceased alive on 12-27-69 19 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE M. Bodenheim M.D.		23B. DATE SIGNED 12-27-69		23C. PHYSICIAN'S NAME (Type) M. BODENHEIMER, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12-29-69		24C. NAME OF CEMETERY or CREMATORY ANSHE EMUNAH, WASHINGTON BLVD.	
25A. DATE REC'D BY HEALTH DEPT. JAN 2 1970		25B. NAME OF REGISTRAR John E. Taylor M.D.		25C. FUNERAL DIRECTOR SOB LEVINSON & BROS. 6010 REISTERSTOWN ROAD	
24D. LOCATION MARYLAND		24E. ADDRESS 2716		24F. ADDRESS 2716	

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BALTIMORE CITY HEALTH DEPARTMENT

69 13012

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 13012

BIRTH NO.

1. NAME OF DECEASED (Type or Print) NEAL ABELMAN		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 60 6160 Greenmeadows Pkwy.		3. DATE PRONOUNCED DEAD Month Day Year Hour 12 29 69 4:30 A.M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 11-20-09		10. AGE (In years last birthday) 60	
11. BIRTHPLACE (State or foreign country) INDIANA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME LOUIS ABELMAN		14. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 2755	
15. MOTHER'S MAIDEN NAME Wm. 7		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) Yes 1951-55	
17. SOCIAL SECURITY NO. 217-20-8509		18. INFORMANT MRS. JOANNE KUSHNER, 6624 EBERLE DRIVE	
19. CAUSE OF DEATH 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:	
22. DATE OF OPERATION		23. CONDITION FOR WHICH OPERATION WAS PERFORMED	
24. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		25. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
26. TIME OF INJURY (APPROX.)		27. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
28. HOW DID INJURY OCCUR?		29. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
30. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		31. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
32. ACTUAL SIGNATURE EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		33. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
34. ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		35. DATE SIGNED 12-29-69	
36. BURIAL CREMATION, REMOVAL (Specify) BURIAL		37. DATE 12-30-69	
38. NAME OF CEMETERY or CREMATORY BNAI ISRAEL		39. LOCATION (City, town, or county) (State) SOUTHERN AVENUE, MARYLAND	
40. DATE REC'D BY HEALTH DEPT. JAN 2 1970		41. NAME OF REGISTRAR 1300 E. Fisher Rd.	
42. FUNERAL DIRECTOR SOL LEVINSON & BROS.		43. ADDRESS 6010 REISTERSTOWN ROAD	

1944-45

EXAMINER'S CERTIFICATE OF GRADE

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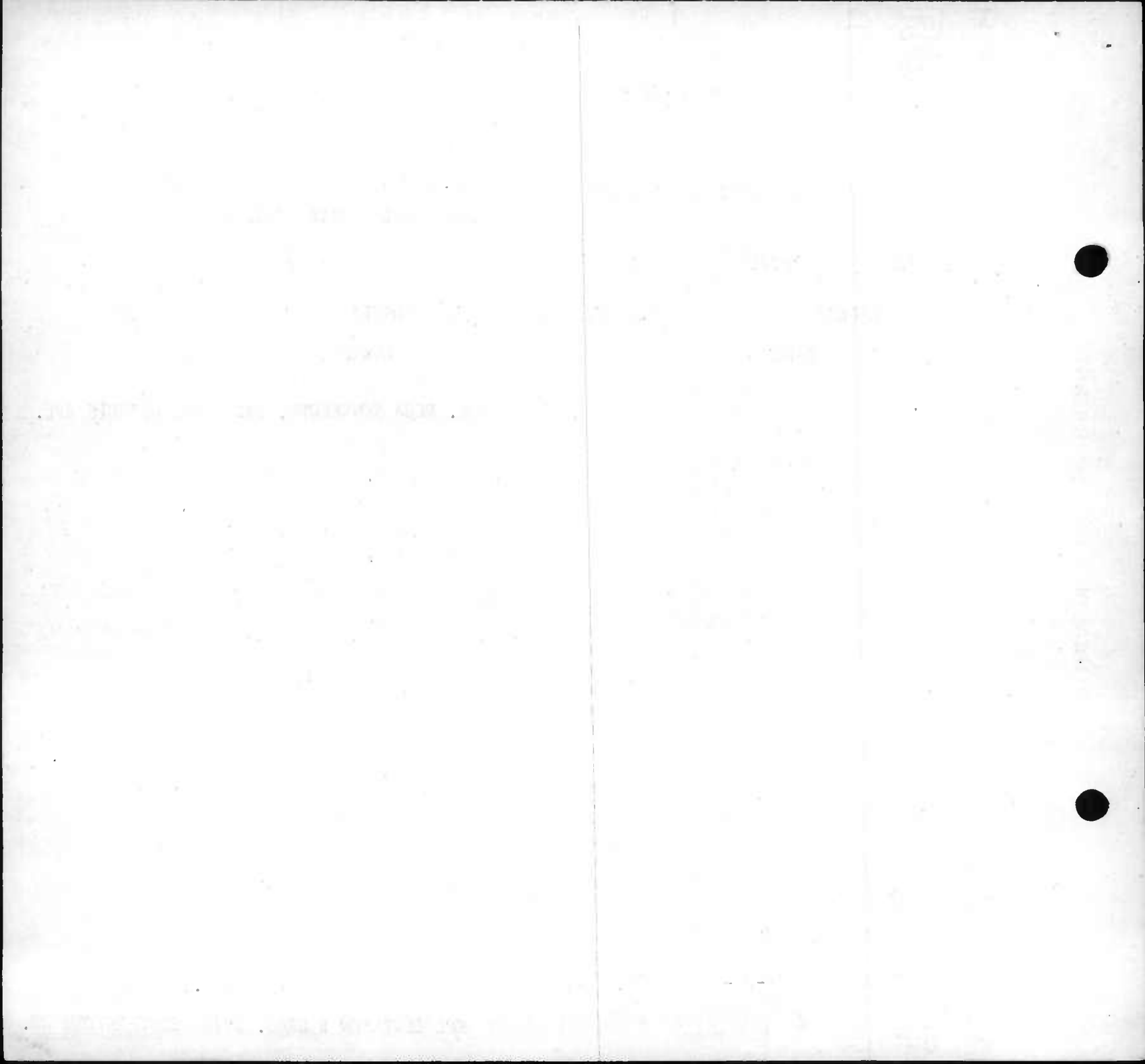
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 13013
BIRTH NO. 69 13013		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) JACOB CATOR		2. DATE AND HOUR OF DEATH 12-29-69 10:30 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 BELVEDERE NURSING HOME		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 27-40 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3406 MENLO DRIVE #21215		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 86	9. AGE (In years lost birthday) 86
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TAILOR		10B. KIND OF BUSINESS OR INDUSTRY CLOTHING		11. BIRTHPLACE (State or foreign country) RUSSIA
13. FATHER'S NAME ? CATOR		14. MOTHER'S MAIDEN NAME UNKNOWN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS MRS. REBA SONNEBORN, 5929 PARK HEIGHTS AVE.
18. 436.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebrovascular accident (B) DUE TO, OR AS A CONSEQUENCE OF: (C) 24 hours		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		Urinary tract infection		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 19 48 to Dec. 29 19 69 , that (I) (was) lost saw the deceased alive on Dec. 29 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (Was) (did) view the body after death.				
23A. SIGNATURE Herbert H. Gundersheimer M.D. DEGREE				23B. DATE SIGNED 12-29-69
23C. PHYSICIAN'S NAME (Type) HERBERT GUNDERSHEIMER DEGREE		23D. ADDRESS 901 Lake Drive		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 12-30-69	24C. NAME OF CEMETERY or CREMATORY AITZ CHAIM		24D. LOCATION (City, town, or county) (State) WASHINGTON BLVD., MARYLAND
25A. DATE REC'D BY HEALTH DEPT. JAN 2 1970		25B. NAME OF REGISTRAR Robert J. Belcher		25C. FUNERAL DIRECTOR ADDRESS SOL DEVINSON & BROS. 6010 REISTERSTOWN RD.



69 13014 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 13014

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) NOAH AXELMAN		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 42 Sinai Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 12 28 69 11:50 P.M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 2717	
9. DATE OF BIRTH 1-26-27		10. AGE (In years last birthday) 42	
11. BIRTHPLACE (State or foreign country) RICHMOND, VA.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME RABBI BENJAMIN G. ALEXMAN (Living)		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN	
15. MOTHER'S MAIDEN NAME HANNAH RUBINROTT		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) YES WW II ARMY	
17. SOCIAL SECURITY NO.		18. INFORMANT RABBI BENJAMIN G. AXELMAN, 4829 PARK HEIGHTS AVENUE	
19. CAUSE OF DEATH 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (b) DUE TO, OR AS A CONSEQUENCE OF: (c) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION 12-29-69		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) no		22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (m.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23.	
I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Russell S. Fisher, M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 12-29-69		24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	
24B. DATE 12-30-69		24C. NAME OF CEMETERY or CREMATORY PETACH TIKVAH	
24D. LOCATION (City, town, or county) (State) ROSEDALE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. JAN 2 1970	
25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC. REISTERSTOWN RD.	

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69 13015

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 13015

BIRTH NO.		REG. NO.	
1. NAME OF DECEASED (Type or Print) Martha Gordon		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1735 McKean Ave.		3. DATE PRONOUNCED DEAD Month Day Year Hour 12 29 69 4:50 p. M.	
6. SEX female		7. RACE colored	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1502	
9. DATE OF BIRTH 9-2-19		10. AGE (In years last birthday) 50	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Grier		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
15. MOTHER'S MAIDEN NAME Jennie Lee		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no	
17. SOCIAL SECURITY NO. 216-12-7034		18. INFORMANT James Gordon Sr.	
19. CAUSE OF DEATH E 955 X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 3-2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes		22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1735 McKean Ave. 1502	
22D. TIME OF INJURY (APPROX.) Month Day Year Hour 12 29 69 ?		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? shot self		23.	
I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		DATE SIGNED 12/30/69	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-3-70	
24C. NAME OF CEMETERY or CREMATORY Arbutus Cem. Pk.		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 2 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR V. Bailey		ADDRESS Kelson F.H. 1348 Calhoun Street	

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Maryland

U.S.A.

James Grier

Jennie Lee

no

216-12-7034

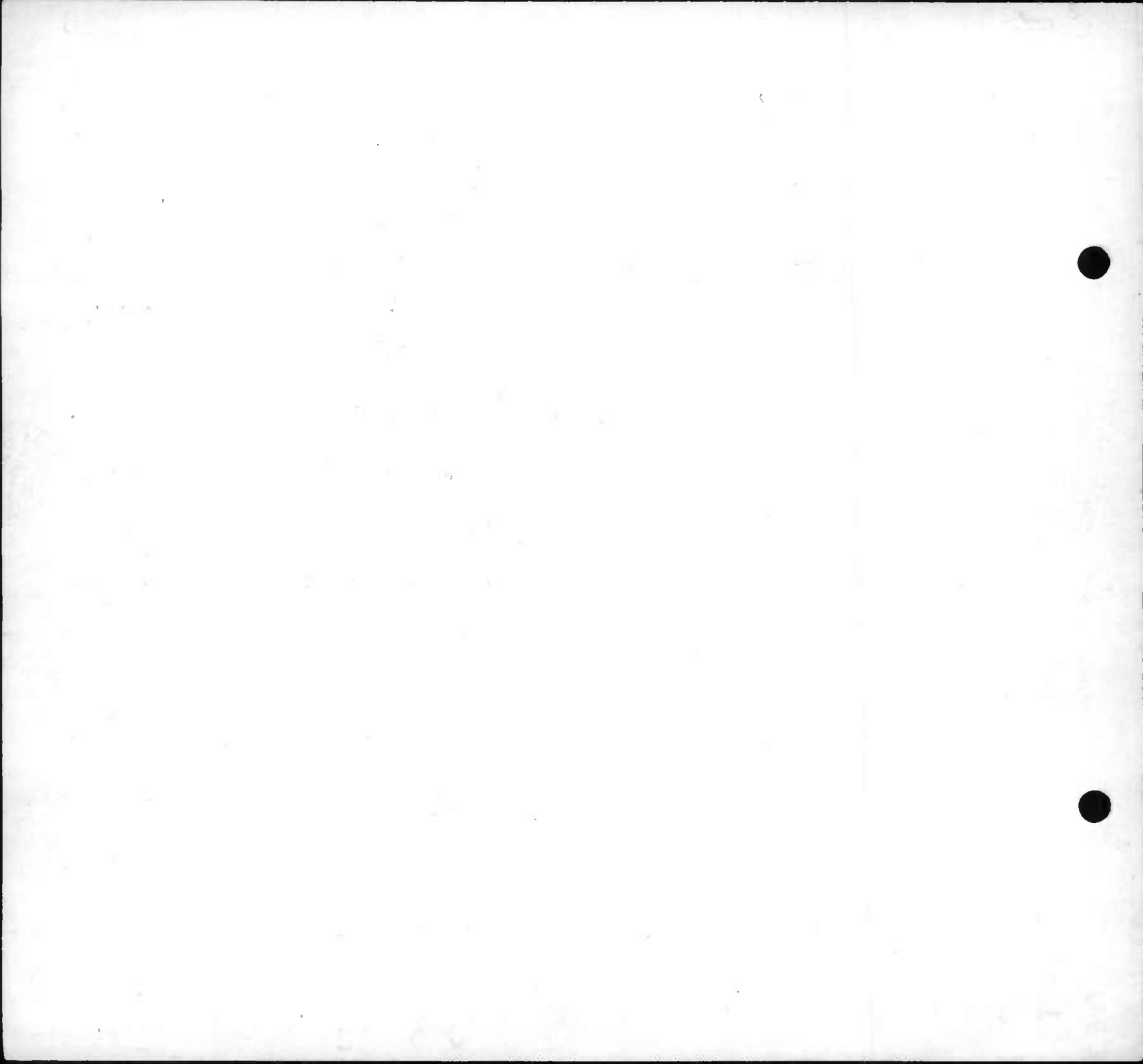
James Gordon St.

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

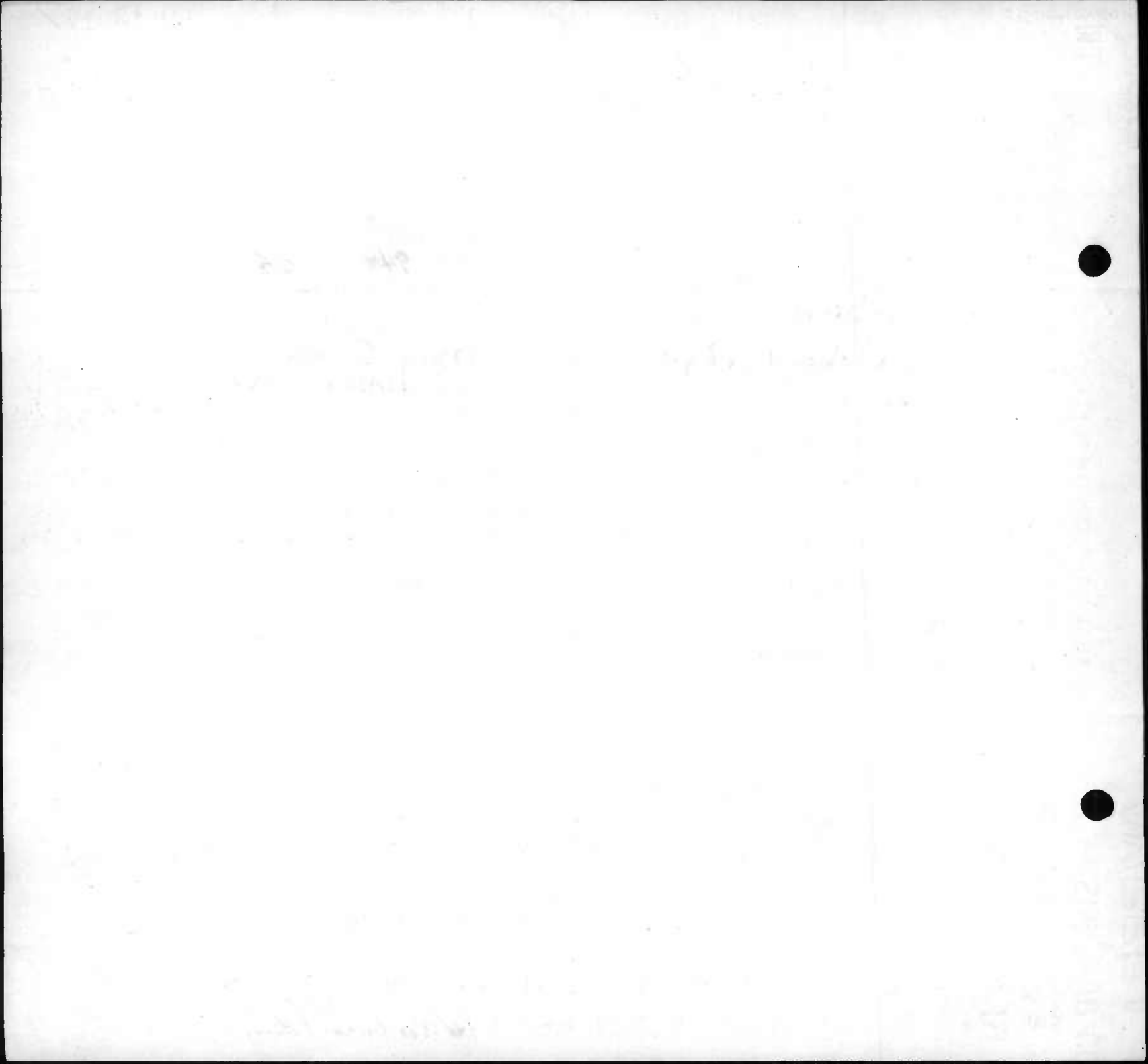
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 13016	
69 13016				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) MAYO, ANNIE		2. DATE AND HOUR OF DEATH 12-28-69 9:30 AM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION HARBORVIEW NURSING HOME BALTO, MD		C. CITY OR TOWN BALTIMORE		E. STREET AND NUMBER 415 Orchard St. BALTIMORE, MD	
5. SEX F	6. RACE Negroid	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-1-95	9. AGE (In years last birthday) 74	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Va.	
13. FATHER'S NAME Jack Eubanks		14. MOTHER'S MAIDEN NAME Angie		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 212-36-8359		17. INFORMANT Sally Tynier ADDRESS 2811 Rockrose Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 250.9 I (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral Vascular Accident		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Arteriosclerosis C.V. disease DUE TO, OR AS A CONSEQUENCE OF: years		(C) Diabetes mellitus years	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/1/69 1969 to 12/28 1969, that (I) (we) last saw the deceased alive on 12/28 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]		23B. DATE SIGNED 12/28/69		23C. PHYSICIAN'S NAME (Type) ALLAN H. MACAT MD	
23D. ADDRESS 2 E Red St		23E. CITY OR TOWN BALTIMORE		23F. STATE MD	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-2-70		24C. NAME OF CEMETERY OR CREMATORY Church Cemetery	
24D. LOCATION (City, town, or county) (State) Howardville, Virginia		24E. DATE REC'D BY HEALTH DEPT. JAN 2 1970		24F. NAME OF REGISTRAR J. E. Taylor MD	
24G. FUNERAL DIRECTOR Kelson F.H.		24H. ADDRESS 1348 Calhoun St.		24I. CITY OR TOWN BALTIMORE	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 13017		BALTIMORE CITY HEALTH DEPARTMENT		69 13017	
BIRTH NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) ELLIOTT RESTON POPE		2. DATE AND HOUR OF DEATH 12-31-69 7:30 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Bolton Hill Nursing Center		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 1901 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 304 N. Mount Street			
5. SEX M	6. RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-9-94	9. AGE (In years lost birthday) 75
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) North Carolina	
13. FATHER'S NAME Richard Pope		14. MOTHER'S MAIDEN NAME Mary Sudden			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT HAZEL JONES ADDRESS ADMISSION RECORD 203 Riggs Ave	
18. 412.13+303.2 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Pneumonia ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. arteriosclerotic heart disease chronic alcoholism		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12/27/69 years year	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/15 19 69 to 12/31 19 69 , that (I) (we) last saw the deceased alive on 12/31 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE al-manna				23B. DATE SIGNED 12/31/69	
23C. PHYSICIAN'S NAME (Type) ALLAN H. MACHT MD		23D. ADDRESS 2 E Real St Baltimore			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-3-69		24C. NAME OF CEMETERY or CREMATORY mt Auburn Cem.	
24D. LOCATION Balto. Md.		25A. DATE REC'D BY HEALTH DEPT. JAN 2 1970			
25B. NAME OF REGISTRAR W. E. G. G. R. D.		25C. FUNERAL DIRECTOR U. R. Bailey ADDRESS 1050 N. Calhoun St			



G-6301

69 13018

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

69 13018

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Garrett, Howard

2. DATE AND HOUR OF DEATH

12-31-69

6:50 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

University of Md hospital

38

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

Md

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

2002 Druid Hill Avenue

5. SEX

M

6. RACE

N

7. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

8-31-17

9. AGE (In years
last birthday)

52

If Under 1 Yr.

Months Days

If Under 24 Hrs.

Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Howard Garrett Sr.

14. MOTHER'S MAIDEN NAME

Maggie Brown

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

820-01-6223

17. INFORMANT

Mother-Maggie Garrett same

ADDRESS

18. 162.1 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Metastatic Ca of Brain

(B)

DUE TO, OR AS A CONSEQUENCE OF:

Carcinoma of lung

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (H) (this hospital) attended the deceased from Dec 3 1969 to December 31 1969
that (I) (we) last saw the deceased alive on Dec 31 1969 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

23A. SIGNATURE

Paul R. Spink M.D.

DEGREE

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

12-31-69

23C. PHYSICIAN'S
NAME (Type)

23D. ADDRESS

DEGREE

univ of Md Hospital

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

1-3-70

24C. NAME of CEMETERY or CREMATORY

Mt. Auburn Cem.

24D. LOCATION

(City, town, or county)

(State)

Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.

JAN 2 1970

25B. NAME OF REGISTRAR

Robert E. Bailey M.D.

25C. FUNERAL DIRECTOR

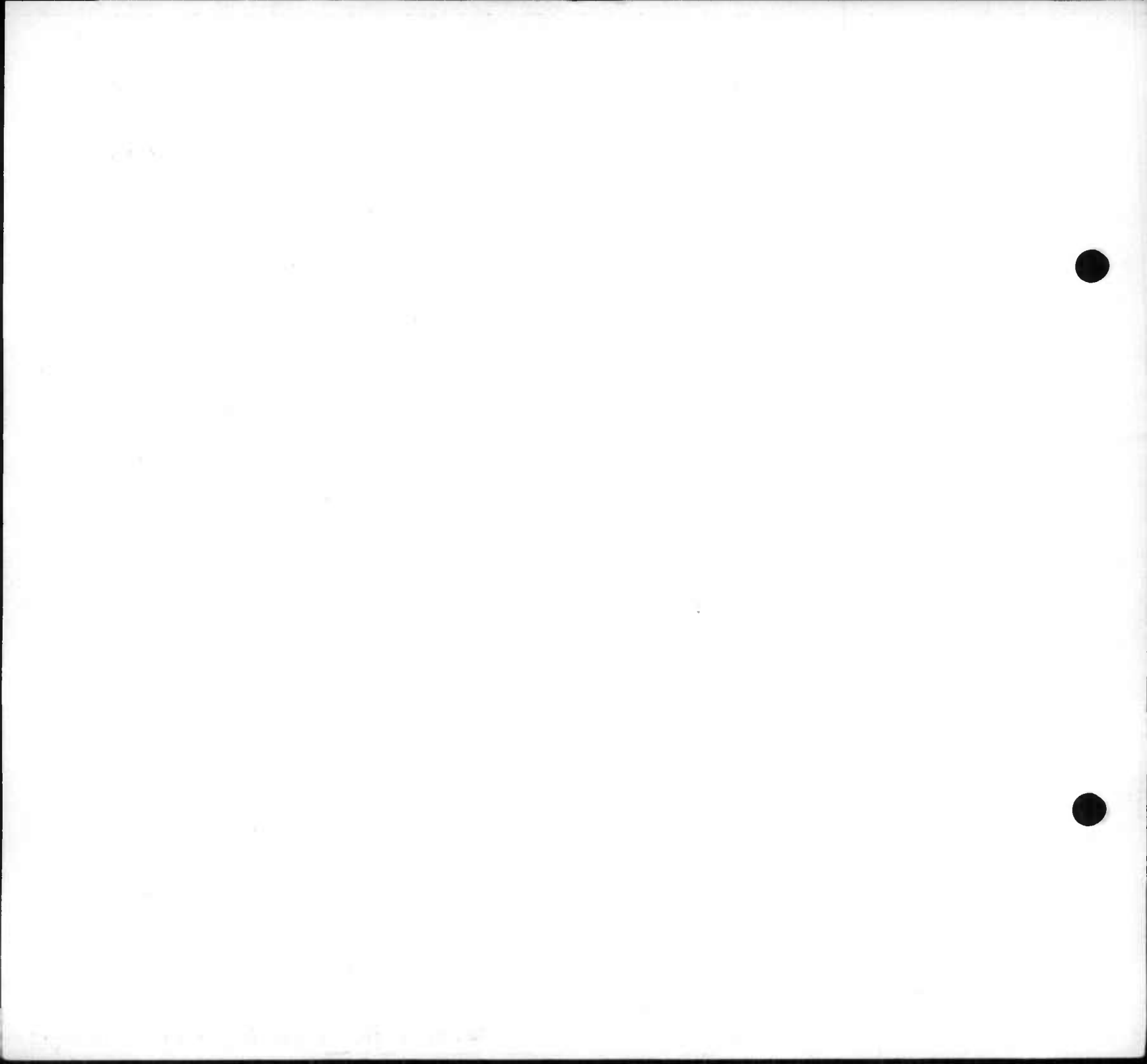
V.R. Bailey

ADDRESS

1348 N. Calhoun St.

FUNERAL DIRECTOR: IMPORTANT

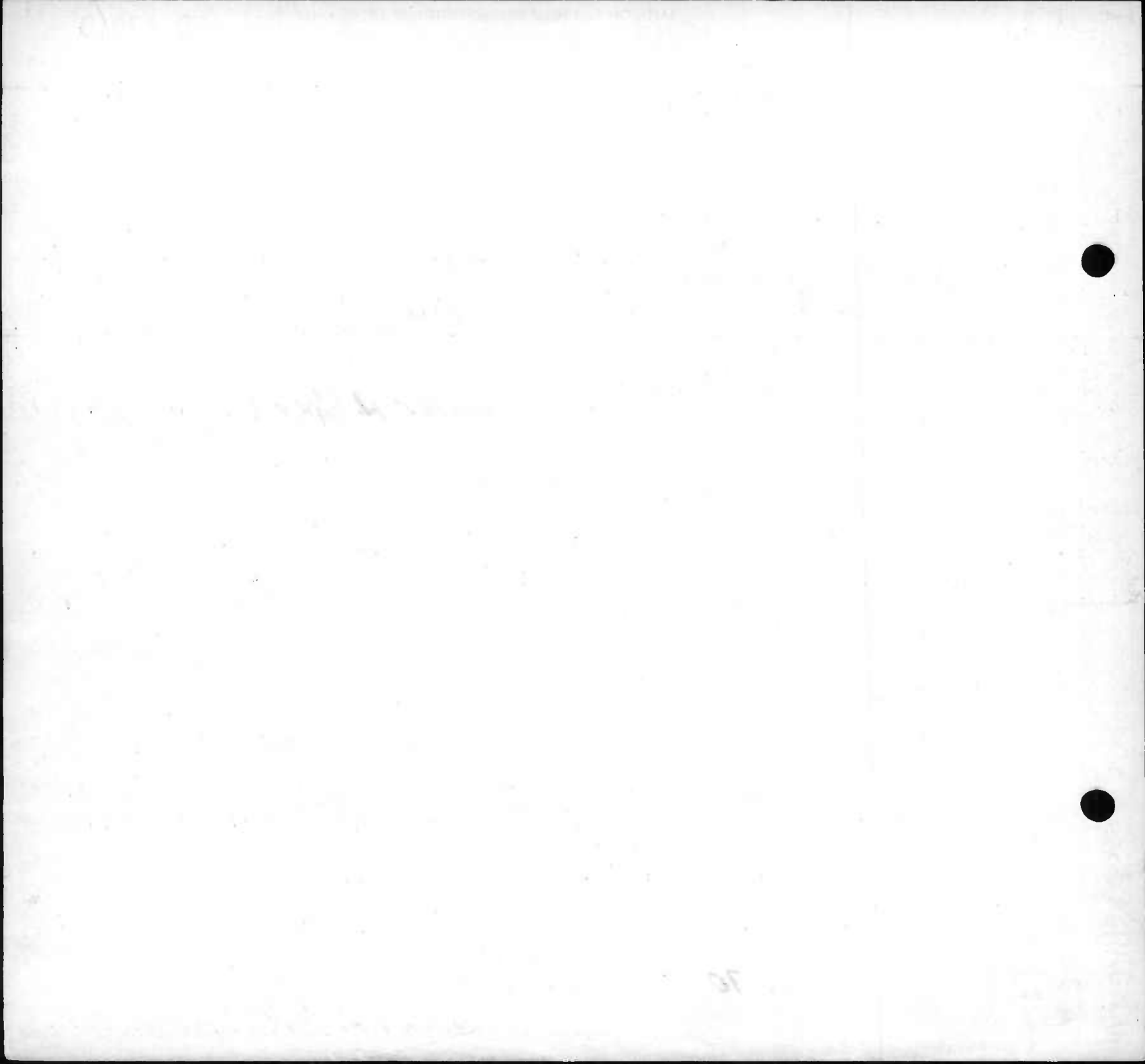
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 13019	
69 13019				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Speed, IDA Lillie</u>		2. DATE AND HOUR OF DEATH <u>12/29/1969</u> <u>6⁰⁰ P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>BALTO</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>90 Key Circle Hospice</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>202 1/2 LINCOLN AVENUE 1702</u>		C. CITY OR TOWN <u>BALTO</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>FEMALE</u>		6. RACE <u>BLACK</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>maid</u>		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <u>8-15-1888</u> 9. AGE (In years last birthday) <u>81 yrs</u>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		11. BIRTHPLACE (State or foreign country) <u>md</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>216-28-3915-A</u>		17. INFORMANT <u>GEORGE H. Speed-Lutherville, Md</u> ADDRESS	
18. <u>440.9 + 180X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Respiratory failure</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Arteriosclerotic vascular disease</u> (C) <u>Co. of the cervix</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>12-27-12-29-69</u> <u>5 yrs?</u> <u>2 yrs?</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>W</u> (this hospital) attended the deceased from <u>9-26-1969</u> to <u>12-29-1969</u> that (I) <u>we</u> lost saw the deceased alive on <u>12-27-1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u> DEGREE				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <u>RICHARD R. RIGLER MD</u>				23D. ADDRESS <u>11 W. OVERLEA AVE #Balt 21206</u>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>1-2-70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>MT. AUBURN</u>	
24D. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 2 1970</u> 25B. NAME OF REGISTRAR <u>[Signature]</u> 25C. FUNERAL DIRECTOR <u>R. E. BAILEY</u> ADDRESS <u>1349 CALHOUN ST.</u>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				69 13020		REG. NO. 69 13020	
BIRTH NO. 69 13020				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Evans, Jay</u>				2. DATE AND HOUR OF DEATH <u>12-30-69</u> <u>12:55</u> A. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Provident Hospital</u> <u>1514 Divison Street</u> <u>Baltimore, Maryland 21217</u>				4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE <u>Baltimore</u> B. COUNTY <u>Maryland</u> C. CITY OR TOWN <u>1402</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1504 Penn. Ave.</u>			
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-12-12</u>	9. AGE (In years last birthday) <u>57</u>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Georgia</u>	
13. FATHER'S NAME <u>John Evans</u>				14. MOTHER'S MAIDEN NAME <u>Lena Evans</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>282-14544</u>		17. INFORMANT <u>Mr. Raymond Jordon-Uncle</u>	
18. <u>571.9</u> I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION <u>2</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Hepatic Coma</u> 20A. AUTOPSY? (Yes or No) <u>No</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>No</u> 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Cirrhosis of the liver</u> 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>Maximal Bleeding from Esophageal Varices</u> 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) <u>December 30, 1969</u> 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? <u>Esophageal Varices</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
22. I certify that (I) (this hospital) attended the deceased from <u>December 6, 1969</u> to <u>December 30, 1969</u> that (I) (we) last saw the deceased alive on <u>December 30, 1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>G. JENCKO MD</u>				23B. DATE SIGNED <u>Dec. 30, 1969</u>		23C. PHYSICIAN'S NAME (Type) <u>Hegego</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>				24B. DATE <u>Jan 3 1970</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary Cemetery</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 2 1970</u>				25B. NAME OF REGISTRAR <u>John E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Joseph H. Hines</u>	
26A. ADDRESS <u>1514 Divison Street Baltimore, Md.</u>				26B. ADDRESS <u>2222 W. North Ave</u>			

*James (Jr.)
G. (Jr.)*

1514 Division Street Baltimore, Md.

x Dec. 30, 1969

December 30, 69

69

December 30,

69

No

*Extraneous matter
removed from
Division of the
Hepatic Canal*

Mr. Raymond Jordan-Uncle 658 Pitcher St

Unemployed

Male Negro

10-12-12

27

x

1504 Penn. Ave.

Maryland

Baltimore

x

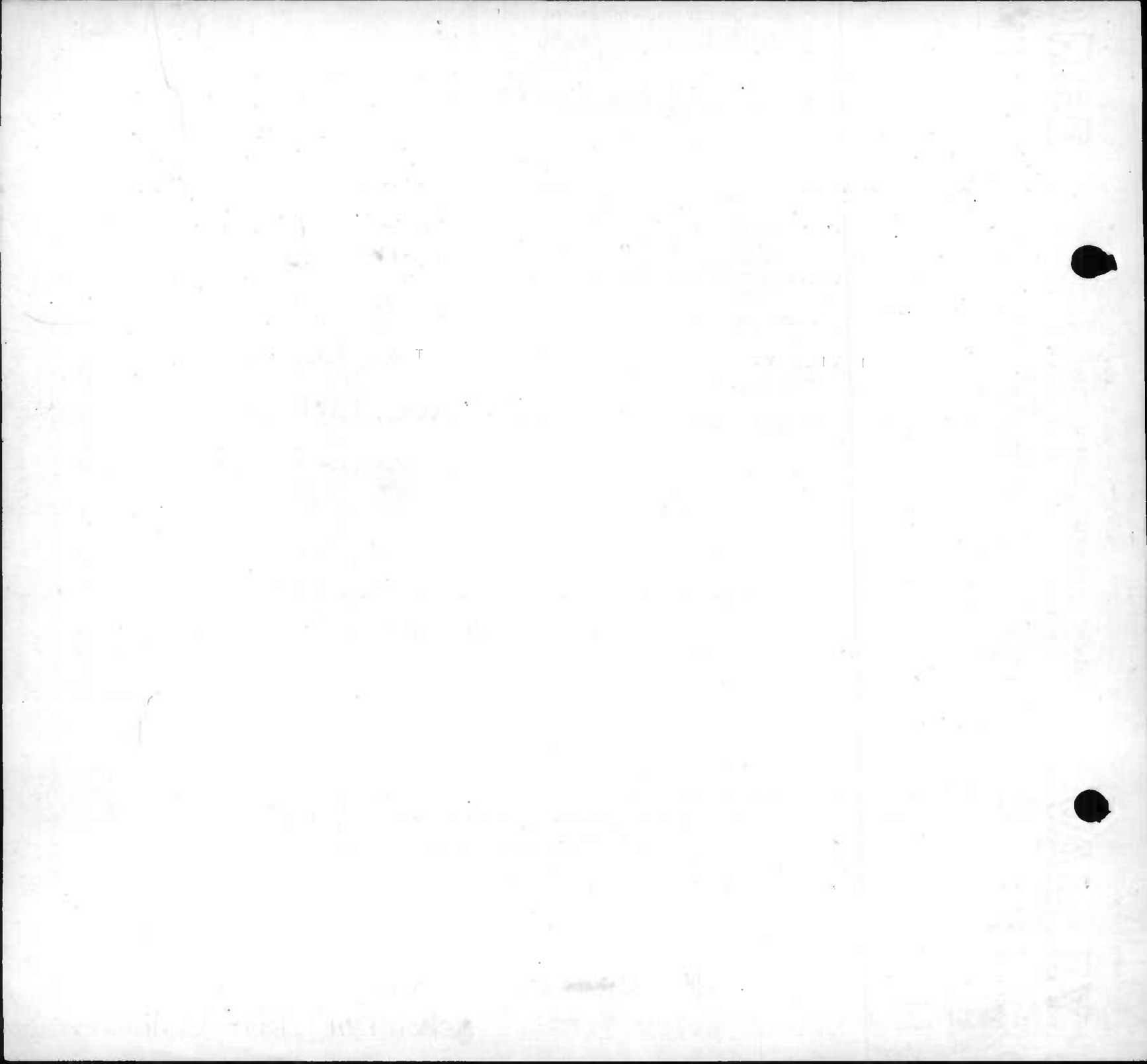
U. S. A.

Georgia

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. THA 69R13021
BIRTH NO. 69 13021				
1. NAME OF DECEASED (Type or Print) TILLET LEVI N. (LIVI)		2. DATE AND HOUR OF DEATH 12/27/69 6PM		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived; if institution: residence before admission) A. STATE MARYLAND B. COUNTY 1602		
FULL NAME OF HOSPITAL OR INSTITUTION JOHNS HOPKINS HOSPITAL		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
501 N. BROADWAY, BALTO MD		E. STREET AND NUMBER 1509 W. MOSHER STREET		
5. SEX M	6. RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 03-01-11	9. AGE (In years last birthday) 58
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) U. C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME LEVI TILLET		14. MOTHER'S MAIDEN NAME BERTHA Womer		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 212 03 9831		17. INFORMANT Myrtle Tillett - wife - some
18. 482.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH KLEBSIELLA PNEUMONIA APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 WKS		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 1) RIGHT CVA 2) PARALYSIS AGITANS				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No.
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) <u>this hospital</u> attended the deceased from NOVEMBER 8, 1969 to DECEMBER 27, 1969 , that (I) (we) lost saw the deceased alive on DECEMBER 27, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Robert S. Weinberg M.D.				23B. DATE SIGNED 12/27/69
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE Jan 6, 1970		24C. NAME of CEMETERY or CREMATORY CHURCH cern.
24D. LOCATION (City, town, or county) (State) WANTED. N.C.				
25A. DATE REC'D BY HEALTH DEPT. JAN 2 1970		25B. NAME OF REGISTRAR Robert S. Weinberg, M.D.		25C. FUNERAL DIRECTOR U. Bailey ADDRESS 1348 Calhoun St.



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

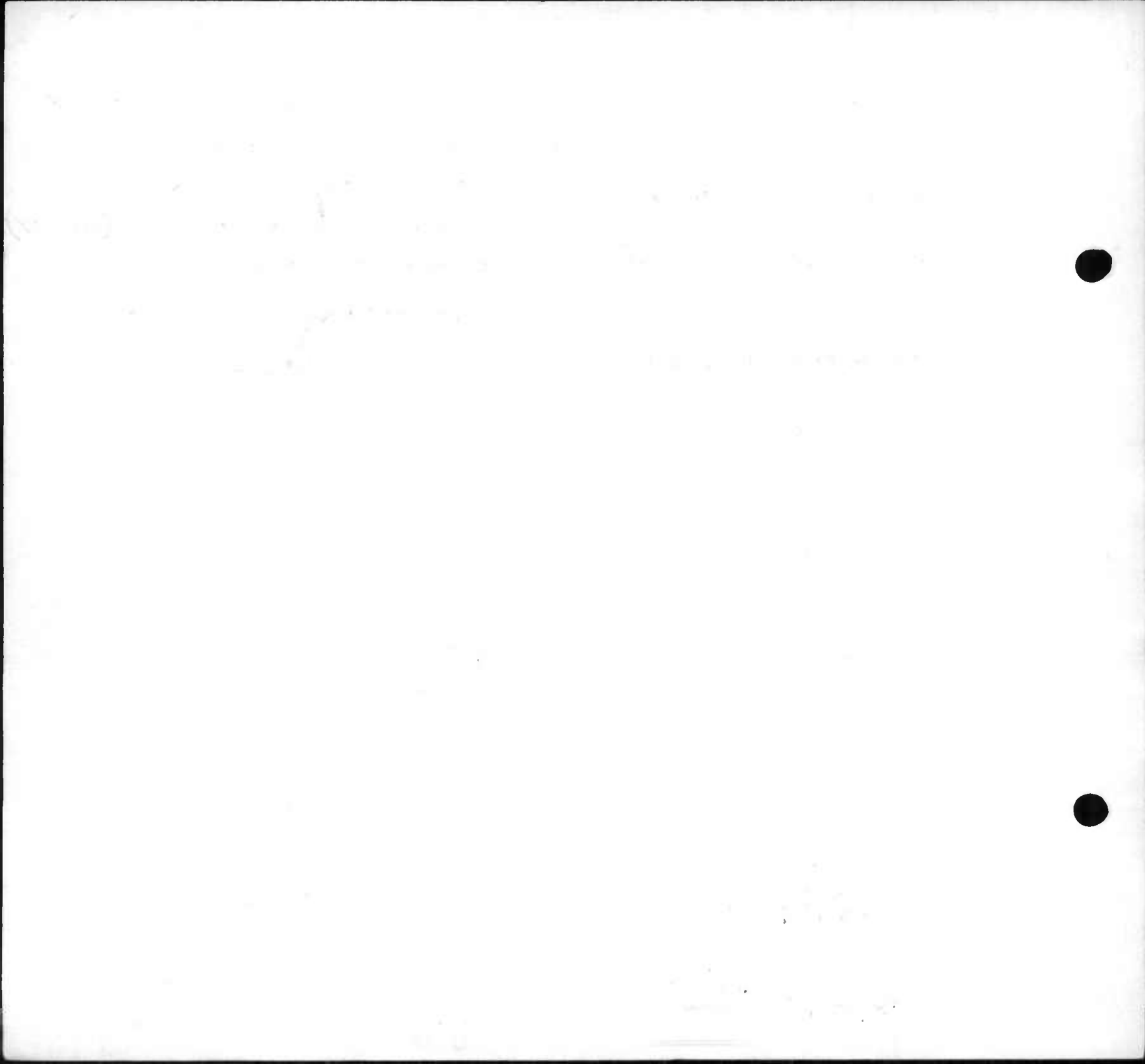
BALTIMORE CITY HEALTH DEPARTMENT				69 13022		REG. NO. 69 13022	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) Walter Joseph Donohue Sr.			
2. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				2. DATE AND HOUR OF DEATH December 23, 1969 7 A. M.			
<div style="font-size: 2em; font-weight: bold;">CERTIFICATE AMENDED</div> <div style="font-size: 1.2em;">FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</div> <div style="font-size: 1.2em;">1-14-70</div>				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
				A. STATE Md. B. COUNTY			
C. CITY OR TOWN Baltimore, Md.				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER 6500 Armstrong Ave.,							
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1905 April 28, 1969		9. AGE (In years lost birthday) 64 yrs.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10B. KIND OF BUSINESS OR INDUSTRY Charing Cross Hardware		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Donohue				14. MOTHER'S MAIDEN NAME Rose Reuschling			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-05-2795		17. INFORMANT Baltimore 15, Md. Mrs. Carolyn M. Donohue, 6500 Armstrong Ave.			
18. 451.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Probable Pulmonary Thrombosis (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Thrombo Phlebitis right leg 1 month (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Dec. 11 1968 to Dec. 23 1969 , that (I) (we) last saw the deceased alive on Dec. 2 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Martin E. Strobel, M.D.				23B. DATE SIGNED 12-24-69			
23C. PHYSICIAN'S NAME (Type) Martin E. Strobel, M.D.				23D. ADDRESS 59 Hanover Rd. Reisterstown, Md. 21136			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Dec. 26, 1969		24C. NAME OF CEMETERY or CREMATORY Lake View Cemetery		24D. LOCATION (City, town, or county) (State) Randallstown, Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 2 1970		25B. NAME OF REGISTRAR John E. Taylor, Jr.		25C. FUNERAL DIRECTOR Joseph H. Koval, Pittanville & Sons		ADDRESS	

B.C. # A-11084 Chief born
4-28-1905 to John & Rosie Donohue
1-14-70 M.H.

Wm. E. Donohue, M.D.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 69 13023		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 69 13023	
1. NAME OF DECEASED (Type or Print) CATHERINE YOST		2. DATE AND HOUR OF DEATH 12/31/69 4 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 4 BON SECOURS Hospital		4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE MD. CITY OF BALTIMORE/04 B. COUNTY C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 839 S. MONTFORD AVE (21234)			
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 09-26-90	9. AGE (In years last birthday) 79	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY U.S.		13. FATHER'S NAME Olendrowicz Felix Olendrowicz		14. MOTHER'S MAIDEN NAME Josephine Sessa	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) -		16. SOCIAL SECURITY NO. 212-14-1543		17. INFORMANT ADDRESS Mr. William Yost, 839 S. Montford Ave	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 151.9 I MARINE Gastrointestinal Bleeding. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Poss gastric carcinoma (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/31 19 69 to 12/31 19 69 that (I) (we) last saw the deceased alive on 12/31 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE W. Attenu		23B. DATE SIGNED 12/31/69		23C. PHYSICIAN'S NAME (Type) MARCELLE P. RESERVE	
23D. ADDRESS 7935 P. PERS PATA Glen Burnie MD 21061					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/3/70		24C. NAME OF CEMETERY OR CREMATORY Loudon Park	
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JAN 2 1970			
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR M. F. SADOWSKI & SONS, 1808 EASTERN AVE			



69 13024

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO.

69 13024

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

REED, RUTH M.

2. DATE AND HOUR OF DEATH

DECEMBER 29, 1969 3:00P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

ST. AGNES HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

1051 PARKSLEY AVE 21223

5. SEX

FEMALE

6. RACE

WHITE

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

11/01/98

9. AGE (In years
last birthday)

71

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

RETIRED

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

ROBERT HOBBS

14. MOTHER'S MAIDEN NAME

MARY (NEE WALTERS) HOBBS

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

NONE

16. SOCIAL
SECURITY NO.

213-54-0139

17. INFORMANT

ADDRESS

ST. AGNES HOSPITAL RECORDS

18.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:

Cardiogenic Shock and Pulmonary Edema

(B) DUE TO, OR AS A CONSEQUENCE OF:

Acute Myocardial Infarction

(C) DUE TO, OR AS A CONSEQUENCE OF:

Atherosclerotic Cardiovascular Disease

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).Ventricular Aneurysm and Previous Myocardial
Infarction

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from DECEMBER 29 1969 to DECEMBER 29 1969
that (I) (we) last saw the deceased alive on DECEMBER 29 1969 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

DEGREE

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

12/29/69

23C. PHYSICIAN'S
NAME (Type)

SALVADOR QUIROZ, MD

DEGREE

23D. ADDRESS

BALTIMORE, MARYLAND 21229
ST. AGNES HOSPITAL & WILKENS AVES.24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

Jan. 2, 1970 Meadowridge Cem.

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION

(City, town, or county)

Howard Co. Md.

25A. DATE REC'D BY HEALTH DEPT.

JAN 2 1970

25B. NAME OF REGISTRAR

J. E. Taylor, R.D.

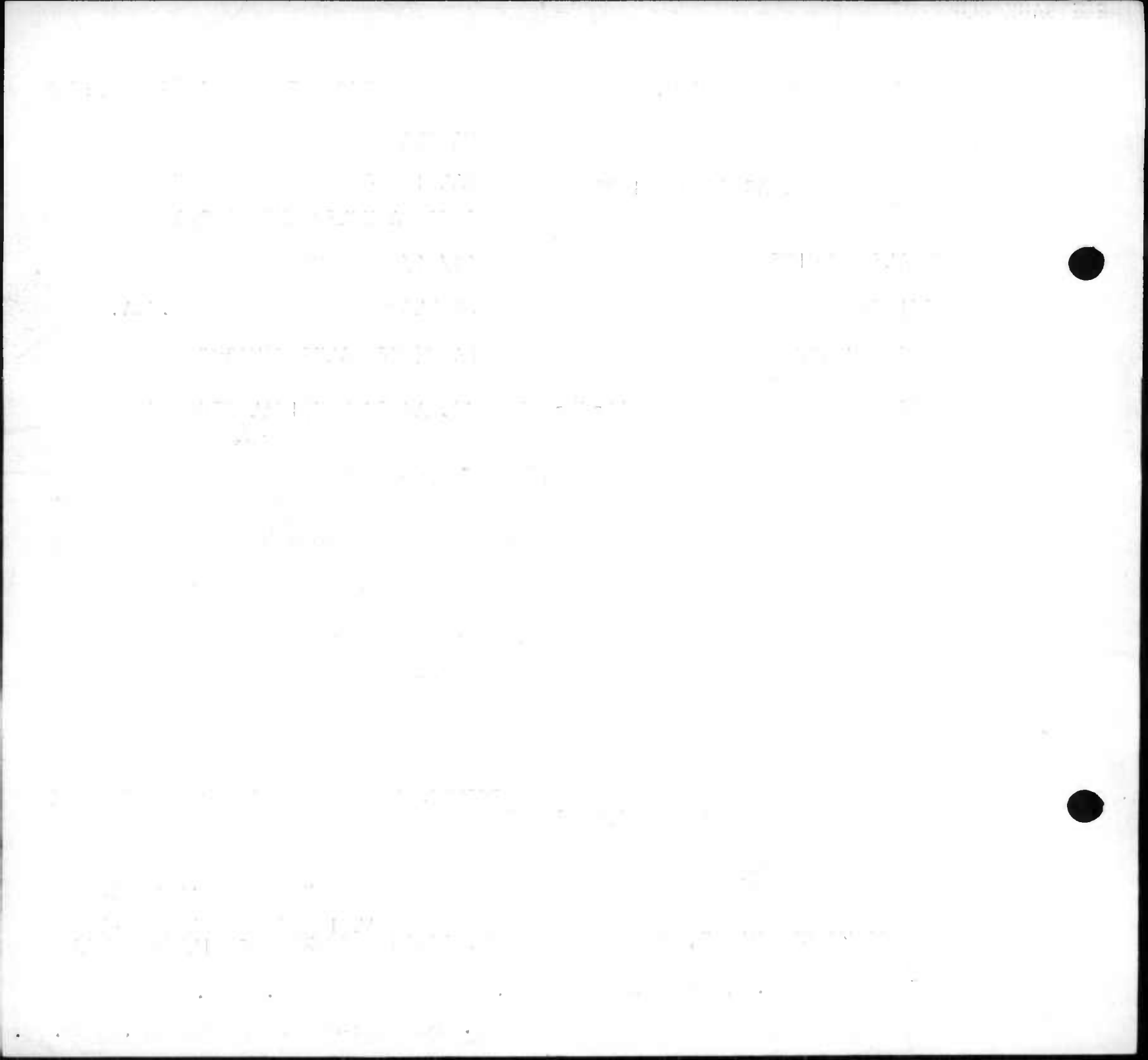
25C. FUNERAL DIRECTOR

T. Schab 3512 Frederick Ave. Balto. Md.

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

LEONARD PETERMAN

2. DATE
OF
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

12

29

69

3:40 p.m.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Lutheran Hospital D.O.A.

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

December 29, 1969 3:40 p.m.

5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

Maryland

Baltimore

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

Randallstown

YES ☐NO ☒

6. SEX

7. RACE

B. MARRIED ☒ NEVER MARRIED ☐

Male

White

WIDOWED ☐DIVORCED ☐

9. DATE OF BIRTH

10. AGE (In years
last birthday)If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

Feb. 22, 1906

63

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

Maryland

U.S.A.

13. FATHER'S NAME

George C. L. Peterman

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

Contractor

Plumbing & Heating

15. MOTHER'S MAIDEN NAME

Lula May (Davidson)

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL
SECURITY NO.

216-32-5833

18. INFORMANT

ADDRESS

Mrs. Udell Peterman 3604 Fieldstone Road

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) IMMEDIATE CAUSE Carbon monoxide poisoning
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

Road

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

2700 blk. Risterstown Rd.

22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)

12

29

69

2:56

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

Subject found in his truck, unconscious

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D. Deputy Chief Medical Examiner 12/30/69

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

1/2/1970

Meadow Ridge Cemetery

Washington Blvd. Howard Co., Md.

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

JAN 2 1970

J. E. Faber, M.D.

Loring Byers 8728 Liberty Road 21133

ACADEMY BOUND

THE CONVENT

ST. MARY'S

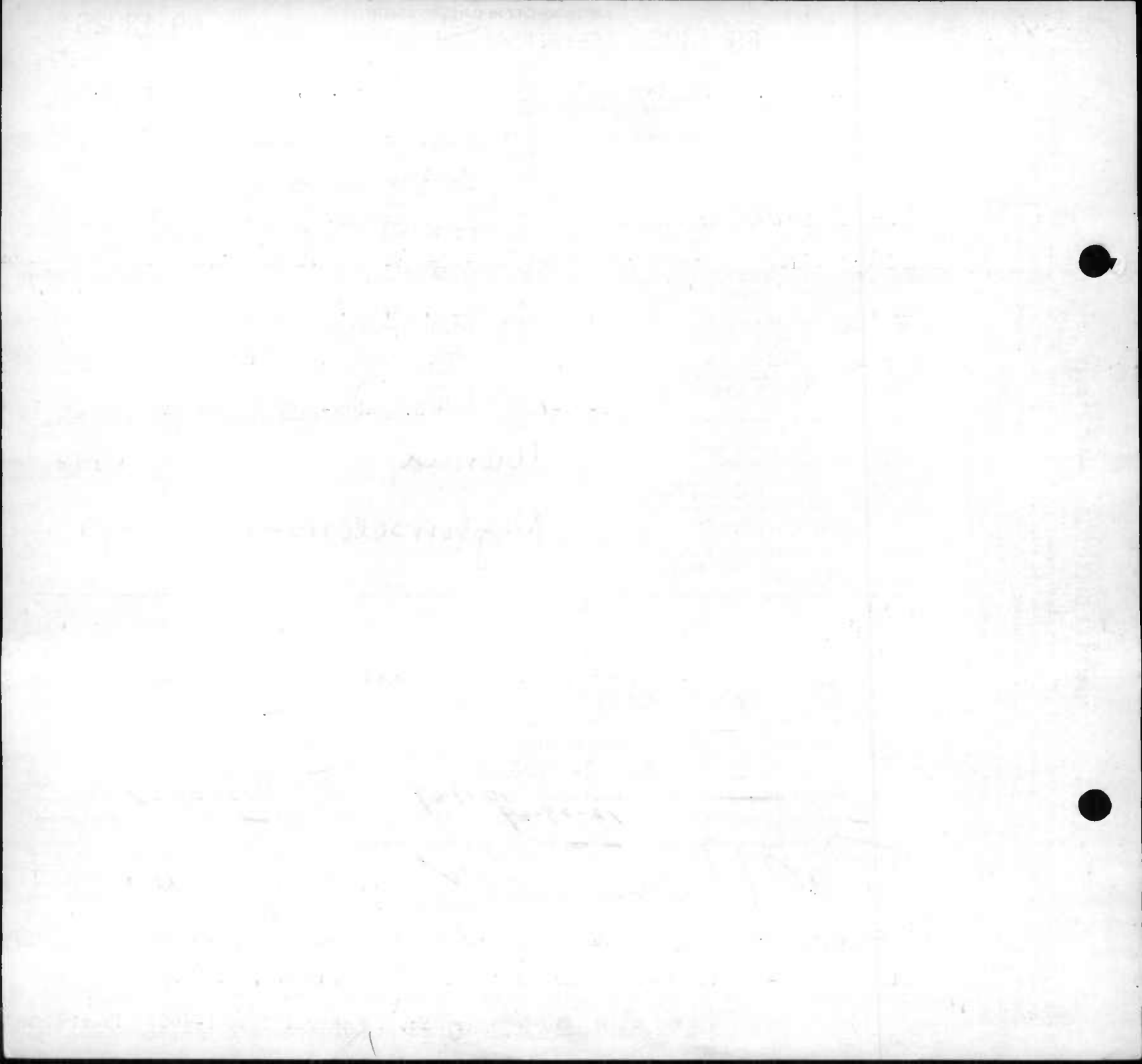
1881

1881

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

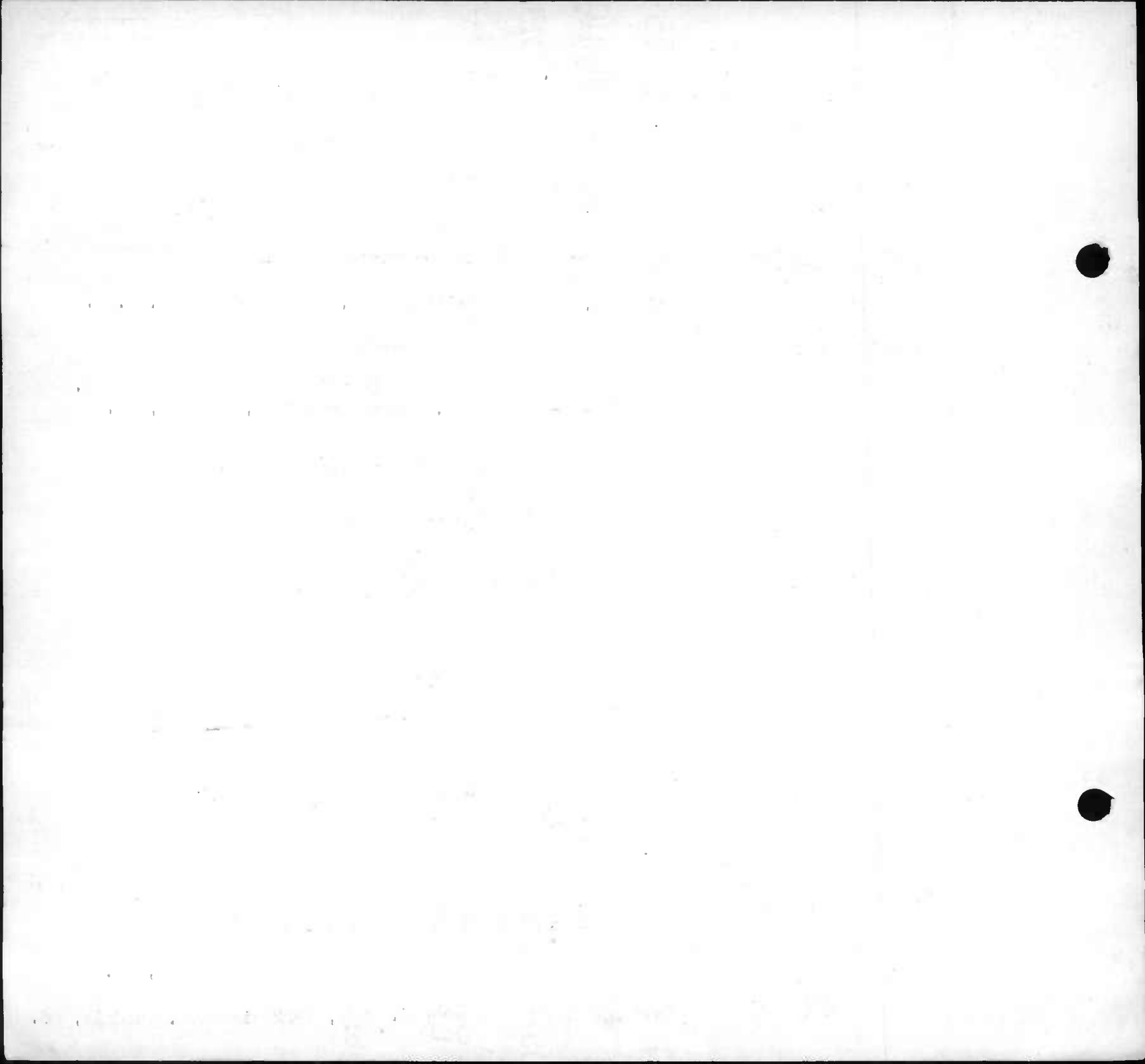
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>69 13026</u>
69 13026		CERTIFICATE OF DEATH		
BIRTH NO.		2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>Alice B. McCauley</u>		Dec. 29, 1969 9:45 p. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>90 Pleasant Manor Nursing Home</u>		A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
		E. STREET AND NUMBER <u>3605 Gwynn Oak Avenue 21207</u>		
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-10-1895</u>	9. AGE (In years last birthday) <u>74</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales Lady</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Balto, Co, Md.</u>
13. FATHER'S NAME <u>Bernard Fallon</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Smith</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>335-09-7331</u>		17. INFORMANT <u>Irene C. Fallon-3605 Gwynn Oak Avenue #7</u>
18. <u>403X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <u>Uremia</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Nephrosclerosis - yrs.</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 mo</u>
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>10-17-69</u> 19 to <u>12-29-69</u> 19, that (I) (was) last saw the deceased alive on <u>12-29-69</u> 19 and that in (my) (last) opinion death occurred on the date and hour and from the causes stated above. (I) (was) (did) view the body after death.				
23A. SIGNATURE <u>Frank G. Kuehn</u>				23B. DATE SIGNED <u>12-31-69</u>
23C. PHYSICIAN'S NAME (Type) <u>FRANK G. KUEHN M.D.</u>		23D. ADDRESS <u>721 MEDICAL ARTS BLDG.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-3-1970</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>				
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 2 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Armadost Funeral Chapel-4600 Liberty Hts</u>



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 69 13027		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 13027	
1. NAME OF DECEASED (Type or Print) <i>Harry E. Swartz</i>		2. DATE AND HOUR OF DEATH <i>Dec 28 1969 8 P. M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Harbor View Nursing Home</i>		A. STATE <i>Md</i>		B. COUNTY <i>Baltimore City</i>	
1213 Light St		C. CITY OR TOWN <i>Baltimore Md</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
90		E. STREET AND NUMBER <i>410 S. Bond St</i>			
5. SEX <i>Male</i>	6. RACE <i>White</i>	MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>4-1-15</i>	9. AGE (In years last birthday) <i>54</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Typesetter</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Gelding Co.</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore Co. Maryland</i>	
13. FATHER'S NAME <i>Harold Swartz</i>		14. MOTHER'S MAIDEN NAME <i>Martha Burrs</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes WWII</i>		16. SOCIAL SECURITY NO. <i>212-09-8157</i>		17. INFORMANT (Aunt) <i>Mrs. George Schreiber, Dundalk, Md.</i> ADDRESS <i>206 Ashwood Rd.</i>	
18. <i>1/60/9 I</i>		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE DUE TO OR AS A CONSEQUENCE OF: <i>Terminal Ca</i>			
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)		(B) DUE TO OR AS A CONSEQUENCE OF: <i>Gen. Disord</i>			
ANTECEDENT CAUSES		(C) <i>Gen. Disord</i>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>9-11</i> 19 <i>69</i> to <i>12-28</i> 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>12-28</i> 19 <i>69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>[Signature]</i>				23B. DATE SIGNED <i>12/29/69</i>	
23C. PHYSICIAN'S NAME (Type) <i>D. S. MONAHAN</i>				23D. ADDRESS <i>8216 Thornton Rd. 3322</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12/30/69</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Woodlawn Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Woodlawn, Md.</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 2 1970</i>		25B. NAME OF REGISTRAR <i>Robert E. [Signature]</i>		25C. FUNERAL DIRECTOR <i>John J. Duda</i> ADDRESS <i>7922 Wise Ave. Dundalk, Md.</i>	



1
C-612

69 13028

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 13028

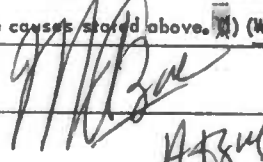
BIRTH NO.		REG. NO.	
1. NAME OF DECEASED (Type or Print) ROBERT GRAVES		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour December 26, 1969 2:07 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 Johns Hopkins Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour December 26, 1969 2:07 A.M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH Feb 11, 1945		10. AGE (In years last birthday) 24	
11. BIRTHPLACE (State or foreign country) Balt. and		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Joseph Francis		14. MOTHER'S MAIDEN NAME Ellen Brown	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel Worker		16. KIND OF BUSINESS OR INDUSTRY	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		18. SOCIAL SECURITY NO.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) E965X ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) club	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 1100 N. Rutland Ave. - E. Moreland Republican Club		22D. TIME (Month) (Day) (Year) (Hour) (APPROX.) 12-22-69 12:25 A.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Shot during altercation	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Isidore Mihalakis, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED December 26, 1969	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Dec 31/69	
24C. NAME OF CEMETERY or CREMATORY Bald. Natl. Cemetery		24D. LOCATION (City, town, or county) (State) 5501 Frederick Ave	
25A. DATE REC'D BY HEALTH DEPT. JAN 2 1970		25B. NAME OF REGISTRAR E. J. Taylor, M.D.	
25C. FUNERAL DIRECTOR Walter E. Elshewer		ADDRESS 1129 N. Carroll	

ACADIA VALLEY

VALLEY PAPER CO

[Handwritten signature]

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

JMK H-6401		BALTIMORE CITY HEALTH DEPARTMENT 69 13029 CERTIFICATE OF DEATH		REG. NO. 69 13029	
1. NAME OF DECEASED (Type or Print) HOERL, EFFIE ETTER Etta		2. DATE AND HOUR OF DEATH DECEMBER 27, 1969 12:30 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST AGNES HOSPITAL CATON & WILKENS AVENUES BALTIMORE, MARYLAND 21229		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER BISHOP LANE 5300			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 04/06/11	9. AGE (In years last birthday) 58	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE & Meter Reader		10B. KIND OF BUSINESS OR INDUSTRY Oil Company		11. BIRTHPLACE (State or foreign country) Greenville, TENNESSEE	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Joseph M. Ricker		14. MOTHER'S MAIDEN NAME Etta Lyda A. Belt	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 218-14-8238		17. INFORMANT ADDRESS ST AGNES HOSPITAL'S RECORDS CATON & WILKENS AVES.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 43017		CAUSE OF DEATH (A) IMMEDIATE CAUSE Subarachnoid DUE TO, OR AS A CONSEQUENCE OF: Hypertension (B) DUE TO, OR AS A CONSEQUENCE OF: Cerebral aneurysm (C) _____			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from DECEMBER 22, 1969 to DECEMBER 27, 1969 that (X) (we) last saw the deceased alive on DECEMBER 27, 1969 and that (X) (our) opinion of death occurred on the date and hour and from the cause stated above. (X) (We) (did) (not) view the body after death.					
23A. SIGNATURE 		23B. DATE SIGNED 12/27/69		23C. PHYSICIAN'S NAME (Type) Agnes M.D.	
23D. ADDRESS ST AGNES HOSPITAL BALTO MD 21229					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/30/69		24C. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT. JAN 2 1970		25B. NAME OF REGISTRAR Robert E. Johnson, M.D.		25C. FUNERAL DIRECTOR Edmondson Ave. Catonsville, Md. 21228	

Handwritten notes and text, mostly illegible due to fading and bleed-through. Some visible words include "The", "of", "and", "in", "on", "at", "from", "to", "by", "with", "without", "under", "above", "below", "between", "among", "against", "towards", "from", "to", "by", "with", "without", "under", "above", "below", "between", "among", "against", "towards".

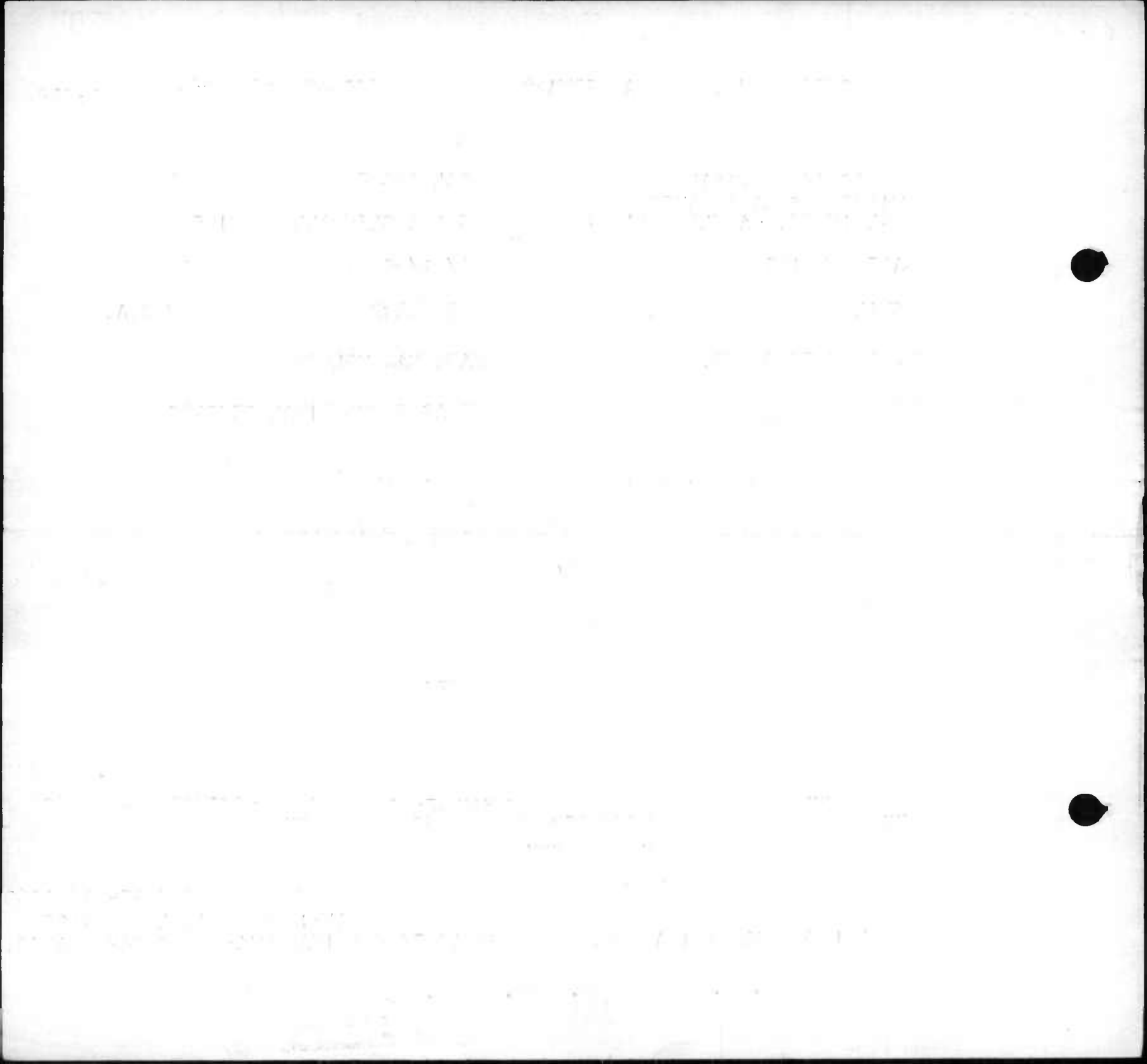
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Handwritten notes and text, mostly illegible due to fading and bleed-through. Some visible words include "The", "of", "and", "in", "on", "at", "from", "to", "by", "with", "without", "under", "above", "below", "between", "among", "against", "towards".

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

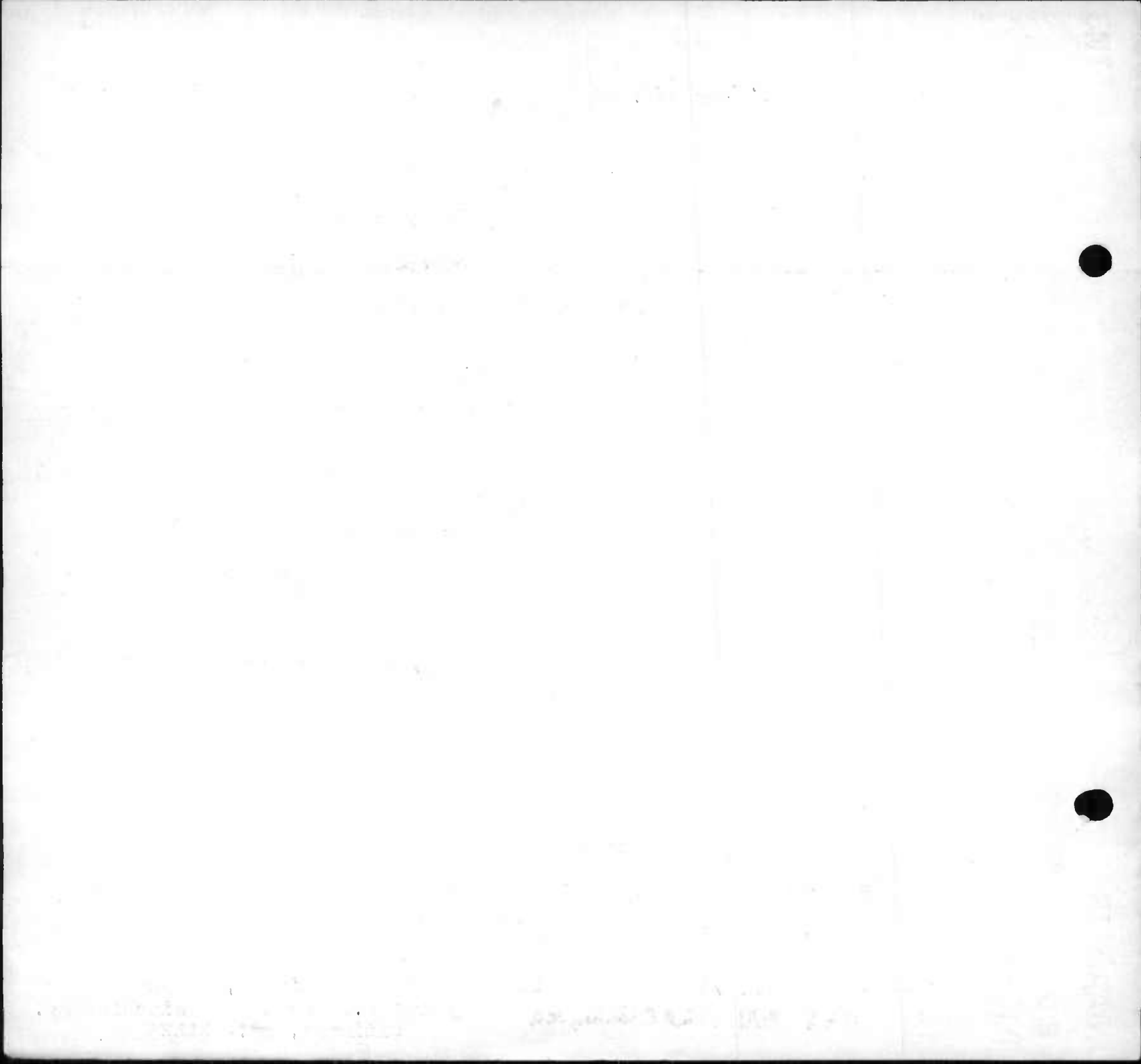
BALTIMORE CITY HEALTH DEPARTMENT				69 13030	
CERTIFICATE OF DEATH				REG. NO. 69 13030	
BIRTH NO. 69-15894 13030		1. NAME OF DECEASED (Type or Print) CHESNO JR. THOMAS EDWARD			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH DECEMBER 28 1969 3:53P.M.			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST AGNES HOSPITAL WILKENS & CATON AVES. BALTIMORE, MARYLAND 21229		4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE MD. B. COUNTY 2834			
5. SEX MALE 6. RACE WHITE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 09/02/69		9. AGE (In years last birthday) 3 26	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHILD		10B. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME THOMAS CHESNO SR.			
14. MOTHER'S MAIDEN NAME CANDICE MARY VAN HOLLEN		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO none			
16. SOCIAL SECURITY NO. none		17. INFORMANT ADDRESS ST AGNES HOSPITAL RECORDS			
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE Respiratory arrest DUE TO, OR AS A CONSEQUENCE OF: (B) Pulmonary atelectasis DUE TO, OR AS A CONSEQUENCE OF: (C) Meningocele, hydrocephalus, meningitis, Septicemia pneumonia			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		as. in (C)			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
20B. (IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?)		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If in Baltimore City, give exact location) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR?			
22. I certify that (X) (this hospital) attended the deceased from NOVEMBER 30 19 69 to DECEMBER 28 19 69 that (X) (we) last saw the deceased alive on DECEMBER 28 19 69 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Krita Apibumyopas, M.D.		23B. DATE SIGNED DECEMBER 28, 1969		23C. PHYSICIAN'S NAME (Type) APIBUMYOPAS KRITA, MD.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE Dec. 30, 1969		24C. NAME of CEMETERY or CREMATORY Balto. Nat. Cem.	
24D. LOCATION BALTIMORE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. JAN 2 1970			
25B. NAME OF REGISTRAR Robert E. Talley, M.D.		25C. FUNERAL DIRECTOR Funeral Estate 736 Edmondson Ave. Baltimore, Md. 21228			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				69 13031		69 13031	
69 13031				CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <i>Frank H. Baldwin</i>				2. DATE AND HOUR OF DEATH <i>Dec. 28 1969</i> <i>11 P</i> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Harbor View Nursing Home</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>70 1213 Light St</i>		A. STATE <i>md</i>		B. COUNTY <i>Balto city</i>	
				C. CITY OR TOWN <i>Balto</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <i>3557 4th St</i>			
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>9/11/03</i>		9. AGE (In years lost birthday) <i>66</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>rite watchman</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Chemical Plant</i>		11. BIRTHPLACE (State or foreign country) <i>Balto md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>Charles Baldwin</i>				14. MOTHER'S MAIDEN NAME <i>Annie Brecker</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>213-03-7100</i>		17. INFORMANT ADDRESS <i>Marie Rudolph 3557 4th St</i>	
18. <i>412.4 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Cardiac Arrest</i> <i>A.S.C.V.D.</i> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>Chronic Brain Scurlet</i> (C) <i>Cor. Art. Sclerosis</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 hrs</i>	
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <i>D</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>12/13</i> 19 <i>69</i> to <i>12/28</i> 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>12/13</i> 19 <i>69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) view the body after death.							
23A. SIGNATURE <i>Kenneth Krulovitz MD</i>				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>12/30/69</i>	
23C. PHYSICIAN'S NAME (Type) <i>Kenneth Krulovitz MD</i>				23D. ADDRESS <i>115 W. Monument St. Balto MD</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12/31/69</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 2 1970</i>		25B. NAME OF REGISTRAR <i>Robert E. Fisher, M.D.</i>		25C. FUNERAL DIRECTOR ADDRESS <i>George J. Gonce 4001 Ritchie Hgy. Baltimore, Md. 21225</i>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 69 13032	
69 13032		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		SHORT JAMES Marion		12/30/69 1:55 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY			
SINAI HOSPITAL OF BALTIMORE		MARYLAND PASADENA			
42		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		PASADENA		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
MALE		WHITE		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH		9. AGE (In years last birthday)		10. UNDER 1 Yr. Months Days	
4/2/11		38			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Painter		Beth. Steel Co.		KENTUCKY	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
John Short		McKnight		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		704 07 6759		LEIB HOGAN M.D. SINAI HOSPITAL	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE		2 MONTHS	
ANTECEDENT CAUSES		DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		METASTATIC CARCINOMA of BONES IN LEFT SCAPULA, RIGHT HIP		2 MONTHS	
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 12/29/69 19 to 12/30 1969 that (I) (we) last saw the deceased alive on 12/30/69 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. ADDRESS		23C. DATE SIGNED	
LEIB HOGAN M.D.				12/30/69	
24A. BURIAL CREMATION REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		1/2/70		Mt. Olivet	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JAN 2 1970		Robert E. Fisher M.D.		George J. Gonce 4001 Ritchie Hgy. Baltimore, Md. 21225	

4479247

Box 230

4/9/11

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4/9/11

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4/9/11

4/9/11

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 13033

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO. 69 13033

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

GIBBONS, SAMUEL C.

2. DATE AND HOUR OF DEATH

12-26-69 1:20 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

SINAI Hospital of Baltimore

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

MARYLAND Anne Arundel 21061

C. CITY OR TOWN

Glen Burnie

D. INSIDE CITY LIMITS?

YES ☐ NO ☒

E. STREET AND NUMBER

109 RIDGELY RD. 5200

5. SEX

MALE

6. RACE

WHITE

7. MARRIED

NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

12-5-19

9. AGE (In years last birthday)

50

If Under 1 Yr. Months Days

If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

CHAFFER

10B. KIND OF BUSINESS OR INDUSTRY

TRUCK DRIVER

11. BIRTHPLACE (State or foreign country)

BALTIMORE MD

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Samuel Gibbons

14. MOTHER'S MAIDEN NAME

(Unknown)

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

Yes

W.W. II

16. SOCIAL SECURITY NO.

705-09-2934

17. INFORMANT

Mrs. Audrey Gibbons (Wife)

ADDRESS

Same As DEPT SINAI HOSPITAL.

18.

179.6 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) IMMEDIATE CAUSE BRONCHO PNEUMONIA
DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

4 weeks.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) ANAPLASTIC CARCINOMA METASTATIC
DUE TO, OR AS A CONSEQUENCE OF:

8 MONTHS.

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

11-5-69

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

BONE BIOPSY PELVIS

20A. AUTOPSY? (Yes or No)

PARTIAL

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

1 (Month) 1 (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11/24/69 19 to 12/26 19 69 that (I) (we) lost saw the deceased alive on 12-26-69 19 1:20 PM and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

[Signature]

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

12-26-69.

23C. PHYSICIAN'S NAME (Type)

LEWIS ROGAN M.D.

23D. ADDRESS

24A. BURIAL CREMATION REMOVAL (Specify)

Burial

24B. DATE

Dec. 30, 1969

24C. NAME of CEMETERY or CREMATORY

Woodlawn Cemetery

24D. LOCATION

Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.

JAN 2 1970

25B. NAME OF REGISTRAR

Robert E. Taylor, Jr.

25C. FUNERAL DIRECTOR

Singleton

ADDRESS

Singleton Funeral Home Glen Burnie, Md.

792015

1994/10/10

22 - 25 - 28

No. 60

1

A-235

37
99

69 13034

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 13034

REG. NO.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

JAMES AUSTEN

2. DATE
OF
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

M.

December 25, 1969

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Mercy Hospital

(DOA)

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

December 25, 1969

8:50 A.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

401

6. SEX

Male

7. RACE

White

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

Jan. 23, 1920

10. AGE (In years
last birthday)

49

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

613 E. Baltimore Street

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

James W. Austen

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

14B. KIND OF BUSINESS OR INDUSTRY

/////

15. MOTHER'S MAIDEN NAME

Ida Heyser

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

yes

W.W. II

17. SOCIAL
SECURITY NO.

411 01 2320

18. INFORMANT

ADDRESS

Mrs. Thelma Presson (sister) Linthicum, Md.

19.

571.8

I

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) IMMEDIATE CAUSE Fatty liver
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (if in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Isidore Mihalakis, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

December 26, 1969

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

Dec. 30/69

24C. NAME of CEMETERY or CREMATORY

U.S. National Cemetery

24D. LOCATION (City, town, or county)

Baltimore, Maryland

(State)

25A. DATE REC'D BY HEALTH DEPT.

JAN 2 1970

25B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

25C. FUNERAL DIRECTOR

R. V. Dwyer

ADDRESS

Singleton Funeral Home
Glen Burnie, Maryland

ACADEMY BOMB

[Handwritten signature]

69 13035

BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 13035

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) R. RICHARD MAC CUBBIN		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 12 23 69 Hour: 7:41 pm.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hospital D.O.A.		3. DATE PRONOUNCED DEAD Month Day Year Hour December 23, 1969 7:41 pm.	
5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 26 4-3			
6. SEX Male	7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH 3/14/1947	10. AGE (In years last birthday) 22	E. STREET AND NUMBER 4127 Balsern Rd. 4127 Balfern Avenue, 21213	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF U. S. A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bureau of Parks		14B. KIND OF BUSINESS OR INDUSTRY City of Baltimore	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO. 220-52-2750	
15. MOTHER'S MAIDEN NAME Margaret (Teves) Maccubbin		18. INFORMANT ADDRESS Margaret Maccubbin, 4127 Balfern Avenue 21213	
19. 304.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE Intravenous narcotism DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12/24/69			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 12/29/1969	24C. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery	24D. LOCATION (City, town, or county) (State) Baltimore, Md.
25A. DATE REC'D BY HEALTH DEPT. JAN 2 1970	25B. NAME OF REGISTRAR Robert E. Farber, M.D.	25C. FUNERAL DIRECTOR ADDRESS Schimmunek Funeral Home 3331 Brehms Lane, Baltimore, Md. 21213	

100-100000

UNITED STATES DEPARTMENT OF JUSTICE

MEMORANDUM FOR THE ATTORNEY GENERAL

RE: [Illegible]

DATE: [Illegible]

SUBJECT: [Illegible]

TO: [Illegible]

FROM: [Illegible]

DATE: [Illegible]

BY: [Illegible]

[Illegible text]

[Illegible text]

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BALTIMORE CITY HEALTH DEPARTMENT

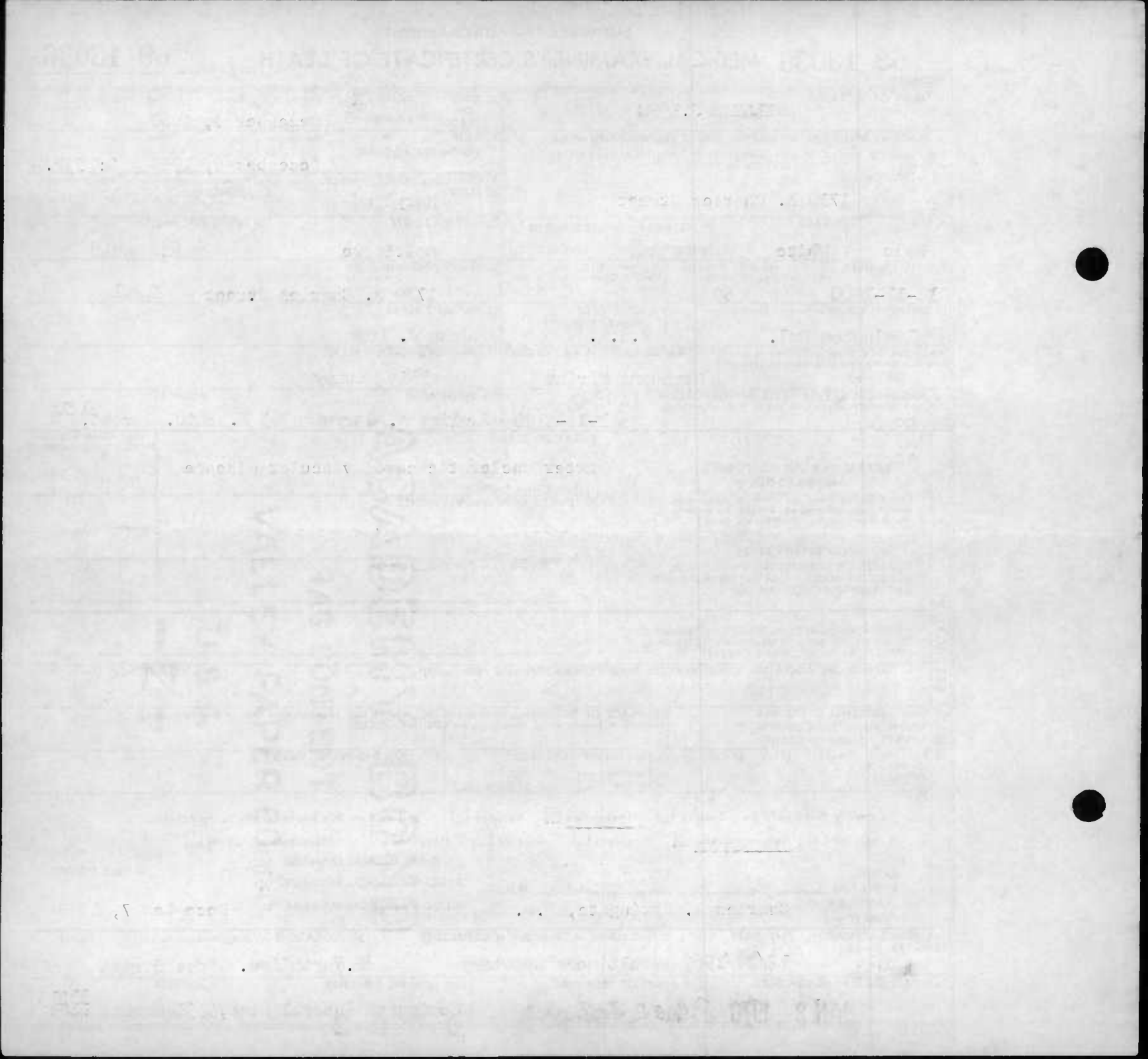
69 13036 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 13036

BIRTH NO.

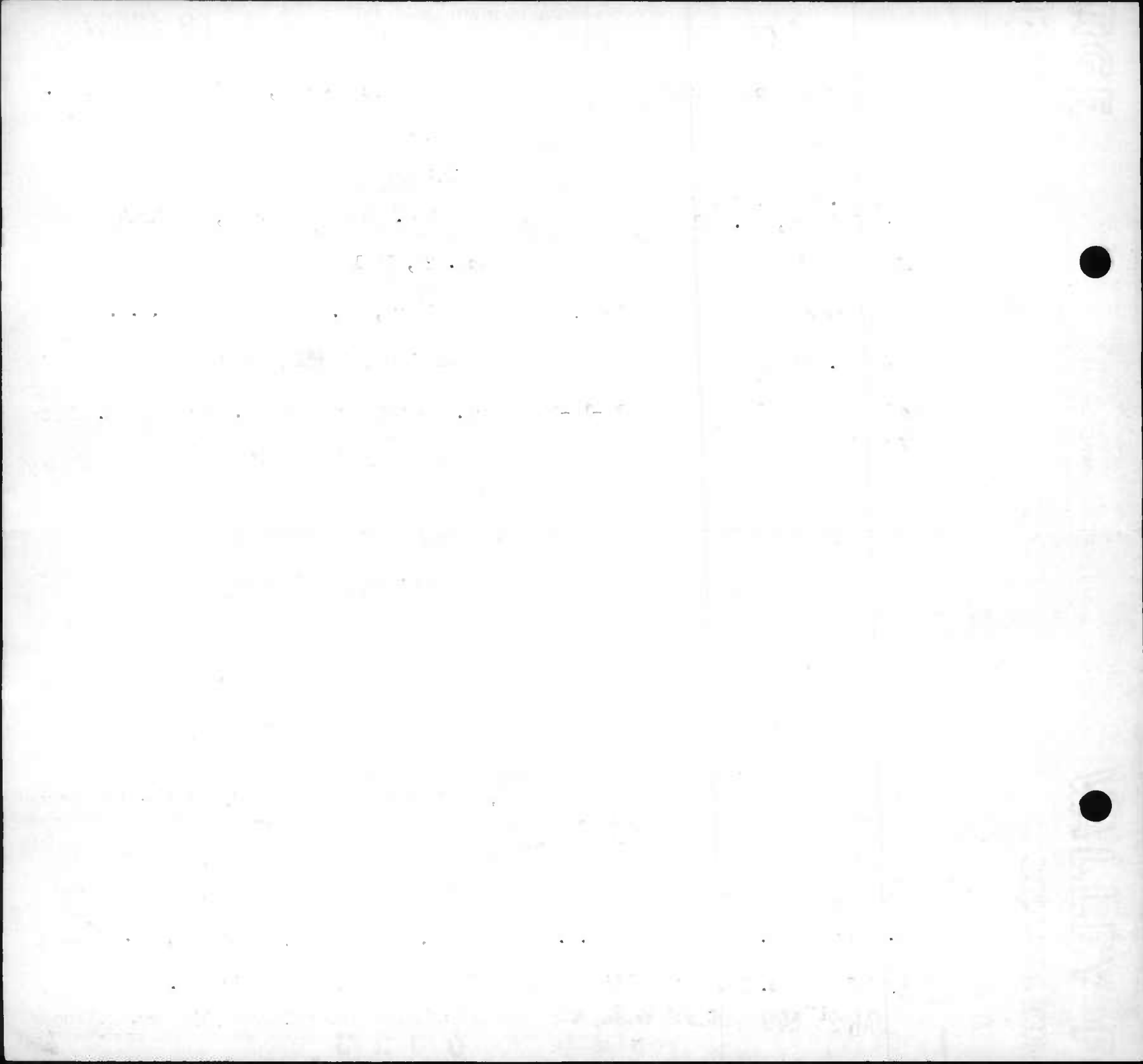
1. NAME OF DECEASED (Type or Print) WILLIAM J. LONG		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month December Day 6 Year 1969 Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1730 N. Charles Street		3. DATE PRONOUNCED DEAD Month December Day 6 Year 1969 Hour 2:25 P.M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1205			
6. SEX Male	7. RACE White	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 10-11-1900		10. AGE (In years last birthday) 69 If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Wilmington Del.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seaman		14B. KIND OF BUSINESS OR INDUSTRY Merchant Marine	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO. 551-16-5794	
18. INFORMANT Pauline M. Street		ADDRESS 303 E. 28th. Street, 21218	
19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
		(B) DUE TO, OR AS A CONSEQUENCE OF:	
		(C) DUE TO, OR AS A CONSEQUENCE OF:	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED December 7, 1969			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/30/1969	
24C. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		24D. LOCATION (City, town, or county) (State) E. North Ave. & Rose Street	
25A. DATE REC'D BY HEALTH DEPT. JAN 2 1970		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Schimmuck Funeral Home, 3331 Brehms Lane		ADDRESS 3331 Brehms Lane	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>69 13037</u>	
69 13037				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Frank Thomas Green</u>			
2. DATE AND HOUR OF DEATH <u>December 26, 1969</u>		2 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>601</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>At Home</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>401 N. Streeper Street</u> <u>Baltimore, Md. 21224</u>		C. CITY OR TOWN <u>Baltimore</u>	
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <u>401 N. Streeper Street, 21224</u>			
5. SEX <u>male</u>	6. RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 25, 1891</u>	9. AGE (In years last birthday) <u>78</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractor</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Own Business</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John W. Green</u>			
14. MOTHER'S MAIDEN NAME <u>Lavina Marshall</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>yes 1</u> <u>WW I</u>			
16. SOCIAL SECURITY NO. <u>217-18-3308</u>		17. INFORMANT <u>Mrs. Theresa Green 401 N. Streeper St. 21224</u>			
18. <u>412.4 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Acute Myocardial Failure</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Asystolic C.V. Disease +</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Pulmonary Emphysema</u> (C) <u>None</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>12-22-69</u> <u>6-22-62</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>None</u>					
19A. DATE OF OPERATION <u>None</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>None</u>		20A. AUTOPSY? (Yes or No) <u>None</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>None</u>		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) <u>None</u>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>None</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>None</u>			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <u>None</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>None</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>6-22-62</u> 19 to <u>12-26</u> 19 <u>69</u> . that (I) (was) last saw the deceased alive on <u>12-22-69</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do not) view the body after death.					
23A. SIGNATURE <u>E. G. Schimunek M.D.</u>				23B. DATE SIGNED <u>12-29-69</u>	
23C. PHYSICIAN'S NAME (Type) <u>Dr. Emmanuel A. Schimunek</u>		23D. ADDRESS <u>M.D. 842 S. East Avenue, Baltimore, Md. 21224</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>Dec. 30, 1969</u>		24C. NAME OF CEMETERY or CREMATORY <u>Baltimore National Cemetery 5505 Frederick Rd.</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md. 21213</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 2 1970</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor, R.D.</u>		25C. FUNERAL DIRECTOR <u>Schimunek Funeral Home 3331 Brehms Lane</u>			



69 13038

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 13038

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Linn ROBERT HEFT		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour December 24, 1969	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour December 24, 1969 4:10 P	
6. SEX Male		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH April 2, 1897		10. AGE (In years lost birth day) 72	
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Trimmer-Lathe operator Owen Yacht Co.	
15. MOTHER'S MAIDEN NAME Ina Thowlinson		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes W W I	
17. SOCIAL SECURITY NO. 309-10-1313		18. INFORMANT Allan Rose & E. Allan Bishop	
19. CAUSE OF DEATH 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED December 25, 1969			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Dec. 27, 1969	
24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery		24D. LOCATION (City, town, or county) (State) Belair Road, Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 2 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Schimunek Funeral Home, 3331 Brehms Lane		ADDRESS 21213	

WATER RESOURCES DIVISION
SALT LAKE CITY, UTAH

REPORT OF THE
SALT LAKE CITY WATER RESOURCES DIVISION

ON THE
SALT LAKE CITY WATER RESOURCES DIVISION

FOR THE
SALT LAKE CITY WATER RESOURCES DIVISION

BY
SALT LAKE CITY WATER RESOURCES DIVISION

FOR THE
SALT LAKE CITY WATER RESOURCES DIVISION

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SALT LAKE CITY WATER RESOURCES DIVISION

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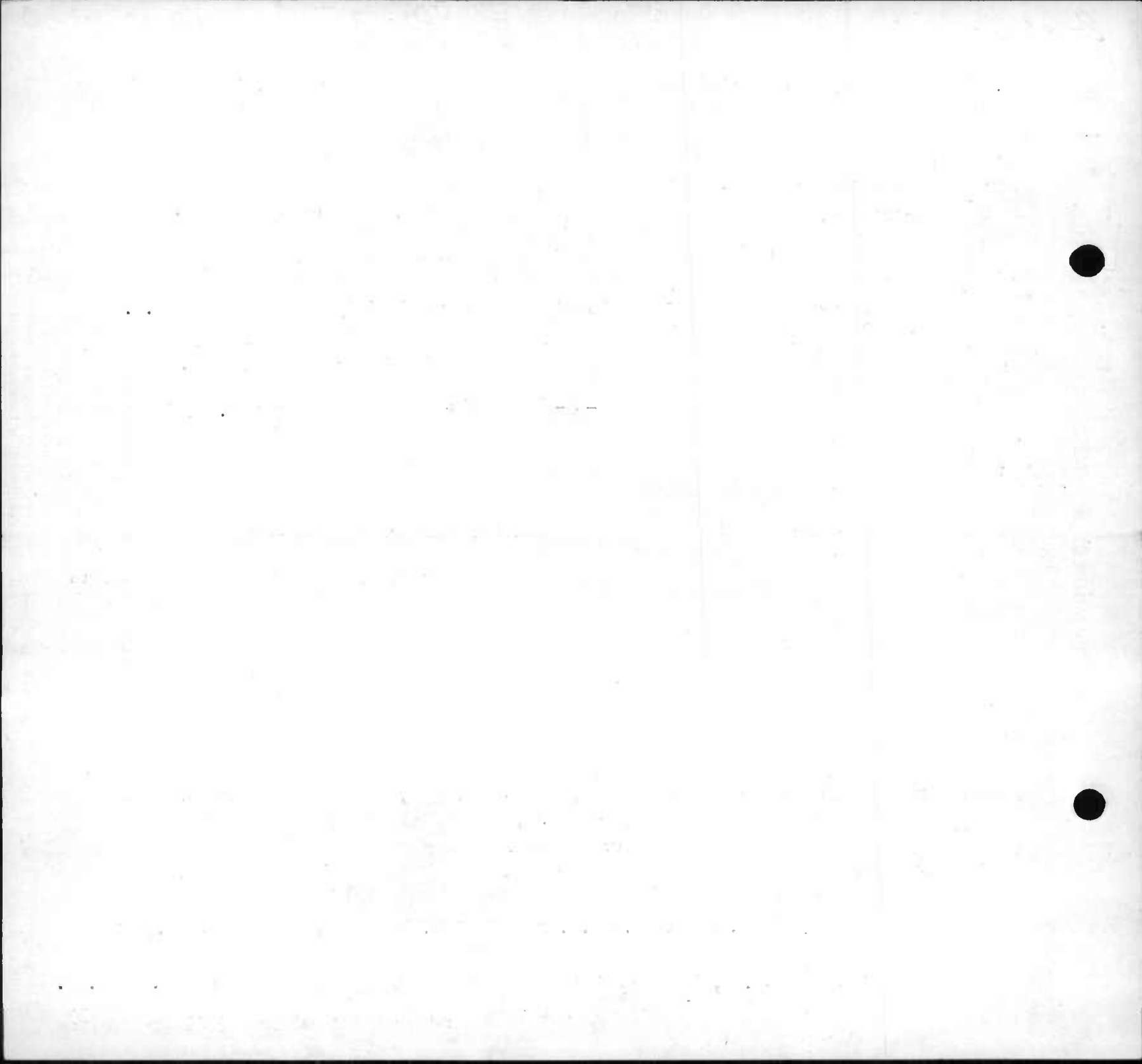
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

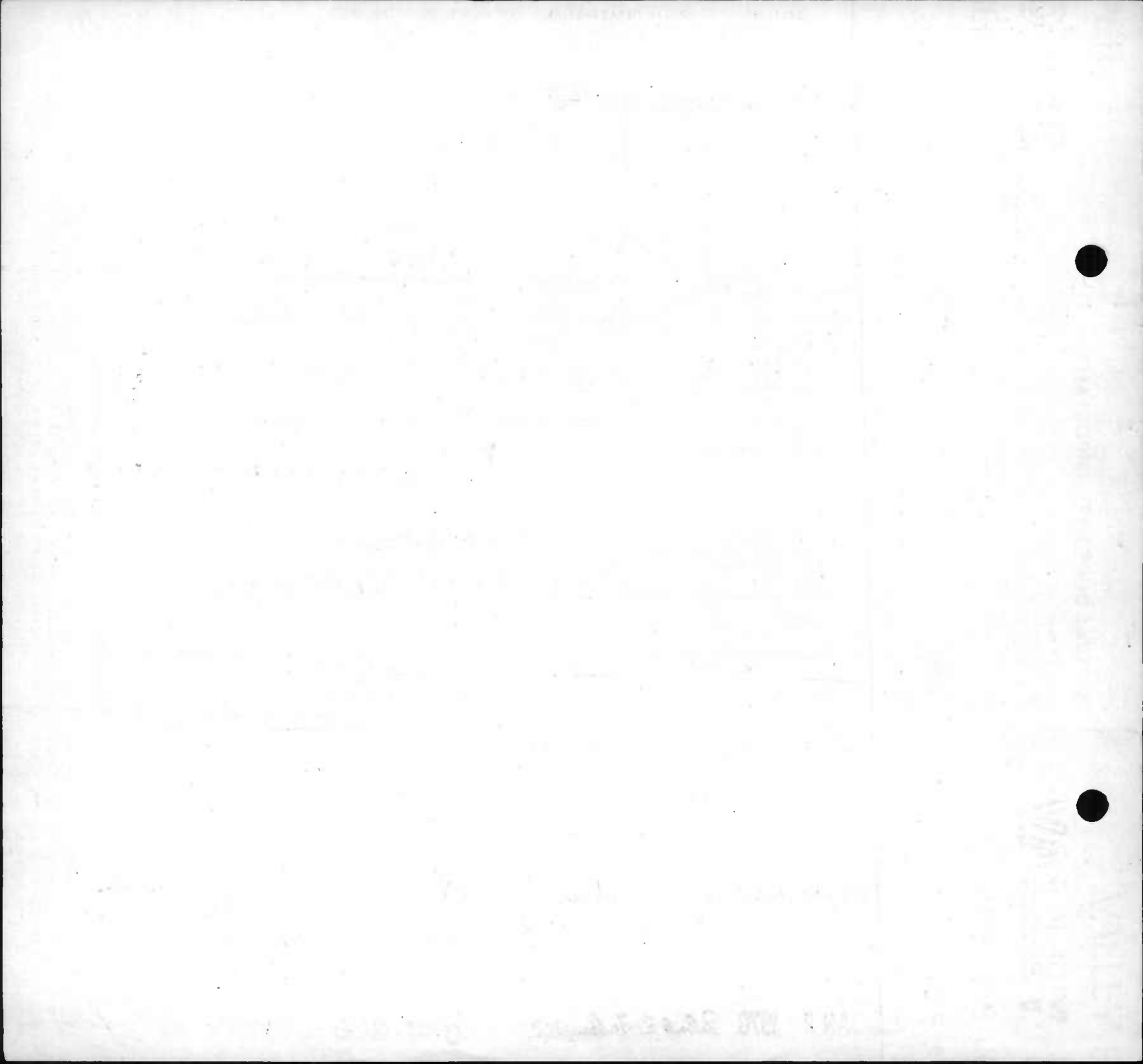
BALTIMORE CITY HEALTH DEPARTMENT										REG. NO. 69 13039	
BIRTH NO. 69 13039										CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Ann Joyce Besser					2. DATE AND HOUR OF DEATH December 26, 1969 12 Noon M.						
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) The Johns Hopkins Hospital Baltimore, Maryland					4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY 703 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 629 N. COLLINGTON AVE.						
5. SEX FEMALE		6. RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-5-14		9. AGE (In years last birthday) 55		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Beautician					10B. KIND OF BUSINESS OR INDUSTRY Self Employed		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A		
13. FATHER'S NAME Unknown					14. MOTHER'S MAIDEN NAME Barbara ?						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no					16. SOCIAL SECURITY NO. 220-03-5589		17. INFORMANT Nicholas Besser		ADDRESS 21205 2317 E. Madison Street		
18. 431.0 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardiac arrest APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 minutes ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Massive intracerebral hemorrhage Severe systemic hypertension 3 days 5 years											
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).											
19A. DATE OF OPERATION 2 none			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED XXXXX			20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) XXX			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) XXX			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) XXX			21E. INJURY OCCURRED While At Work <input checked="" type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>			21F. HOW DID INJURY OCCUR? XXX					
22. I certify that (I) (this hospital) attended the deceased from December 23, 19 69 to December 26, 19 69 , that (I) (we) last saw the deceased alive on December 26, 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE George H. Sack, Jr. M.D.										23B. DATE SIGNED 12/26/69	
23C. PHYSICIAN'S NAME (Type) George H. Sack, Jr., M.D.										23D. ADDRESS 601 N. Broadway, Baltimore, Md., 21205	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE Dec. 30, 1969		24C. NAME of CEMETERY or CREMATORY Baltimore National Cemetery			24D. LOCATION (City, town, or county) (State) 5505 Frederick Ave. Balto. Md.			
25A. DATE REC'D BY HEALTH DEPT.			25B. NAME OF REGISTRAR 96902			25C. FUNERAL DIRECTOR Schimunek Funeral Home			ADDRESS 3331 Brehms Lane 21233		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
69 13040		69 13040		69 13040	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
CLAY BORN CALE CALE		12/22/69 10 45 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 33 JOHNS HOPKINS HOSPITAL		A. STATE Md.		B. COUNTY 2719	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 3108 W. Rogers Ave					
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/19/0	9. AGE (In years last birthday) 59	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MECHANIC		10B. KIND OF BUSINESS OR INDUSTRY Shapers Bros		11. BIRTHPLACE (State or foreign country) Dearfield VA.	
13. FATHER'S NAME VIRGIL M. CALE		14. MOTHER'S MAIDEN NAME ROSE FITZGERALD		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Beaula Cale	
18. 450 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CARDIO RESPIRATORY ARREST DIFFUSE (B) PULMONARY DISEASE DUE TO, OR AS A CONSEQUENCE OF: (C) PULMONARY EMBOLI		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/16 19 69 to 12/22 19 69, that (I) (we) lost saw the deceased alive on 12/22 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Ralph DeFronzo M.D.		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 12/22	
23C. PHYSICIAN'S NAME (Type) RALPH DEFRONZO M.D.		23D. ADDRESS JOHNS HOPKINS HOSPITAL BALTIMORE, MD.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 12/21/69		24C. NAME OF CEMETERY OR CREMATORY Crown Chapel	
24D. LOCATION (City, town, or county) (State) Will Va.					
25A. DATE REC'D BY HEALTH DEPT. JAN 2 1970		25B. NAME OF REGISTRAR Ralph E. Johnson, M.D.		25C. FUNERAL DIRECTOR 6067 Hanford St	

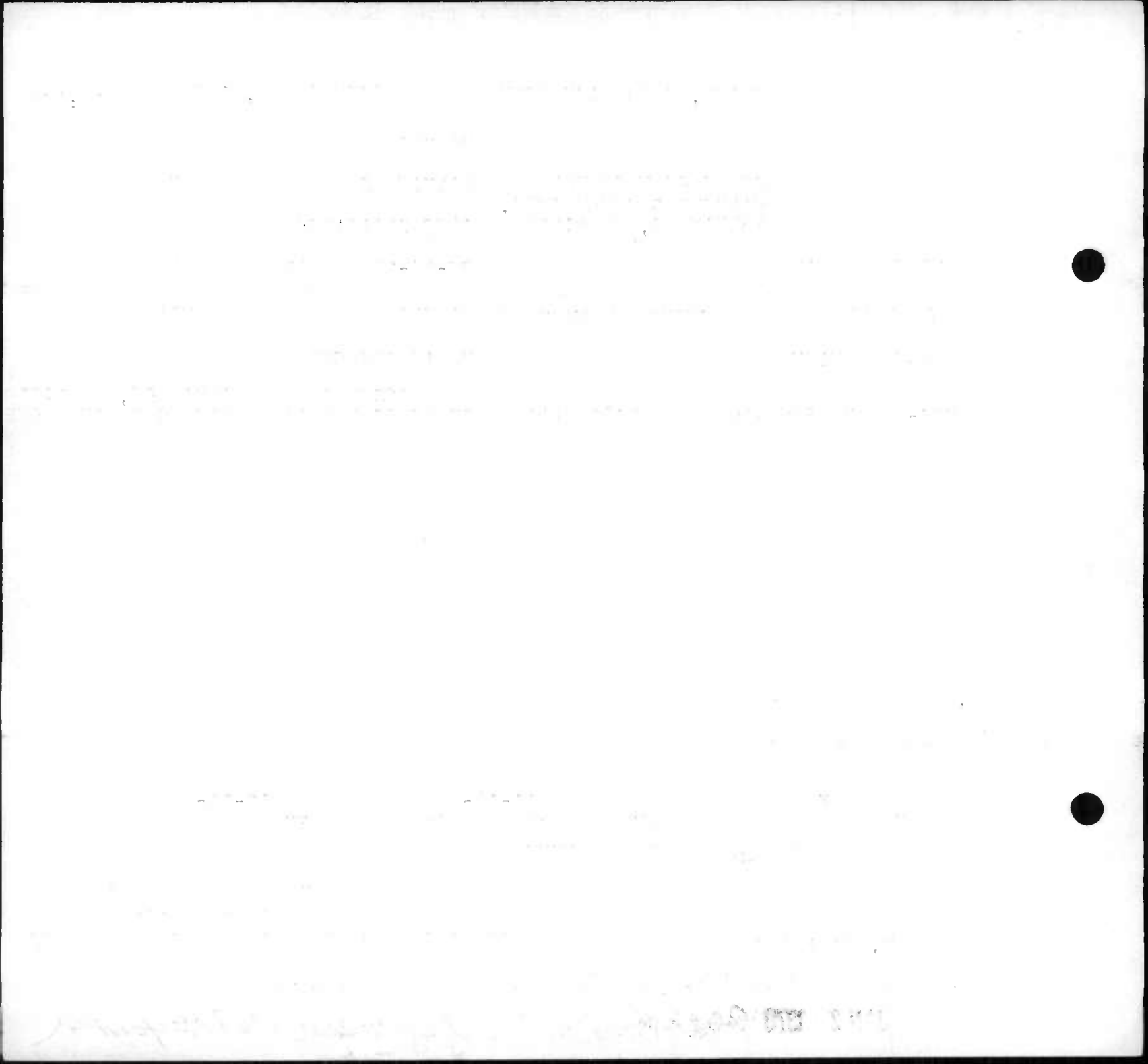


X REG. NO. 69 13041

FUNERAL DIRECTOR: IMPORTANT

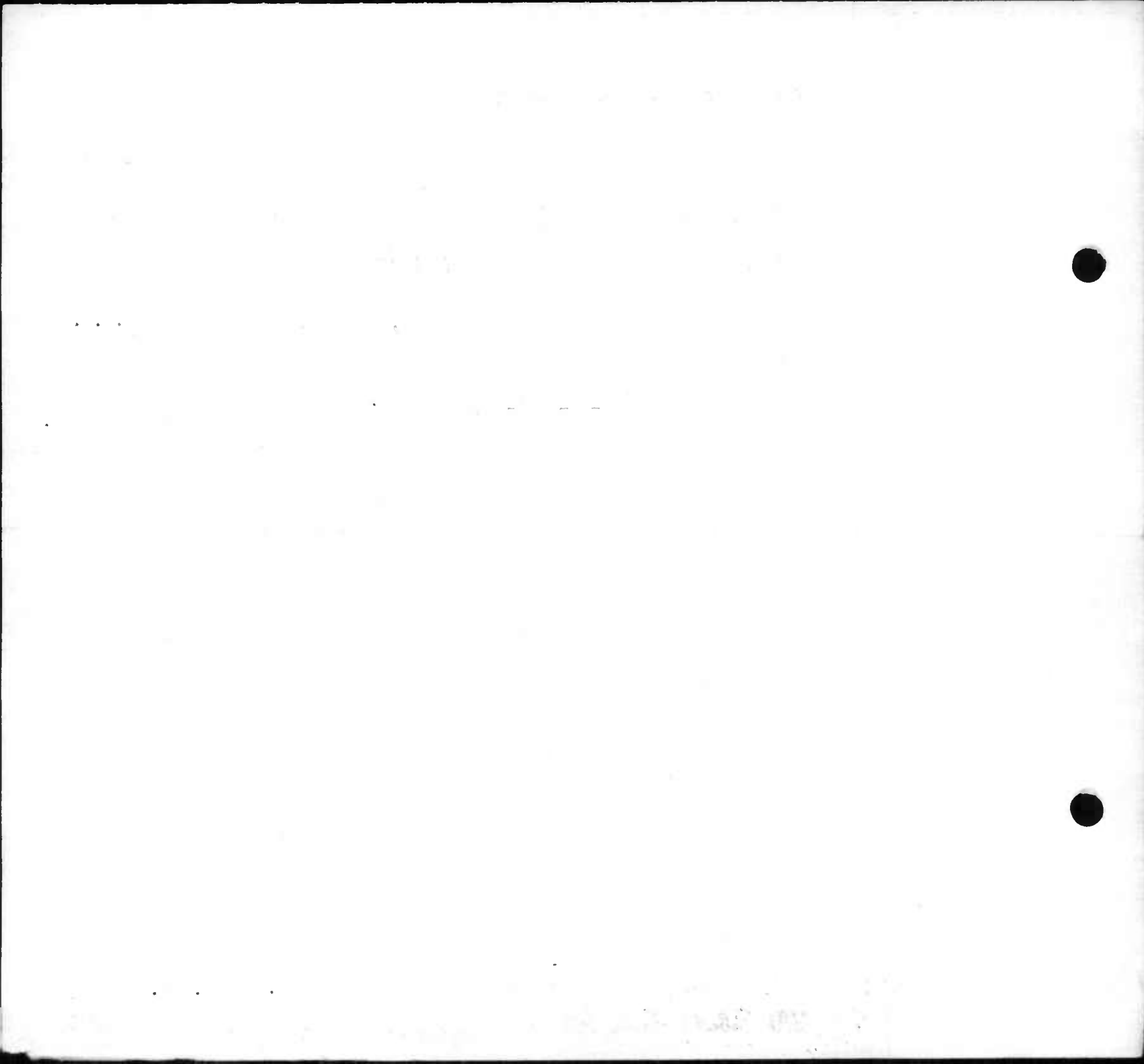
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		10-12-68		10-12-68	
1. NAME OF DECEASED (Type or Print)		SMITH, FREDERICK BENTON		2. DATE AND HOUR OF DEATH DECEMBER 22, 1969 10:45 PM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE B. COUNTY MARYLAND BALTO. CO. 5300		5. SEX MALE	
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST AGNES HOSPITAL WILKENS & CATON AVES. BALTIMORE, MD 21229		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 05-29-27	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STORE KEEPER		10B. KIND OF BUSINESS OR INDUSTRY STATE OF MARYLAND		9. AGE (In years last birthday) 42	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA		11 Under 1 Yr. Months Days 11 Under 24 Hrs. Hours Min.	
13. FATHER'S NAME BENTON SMITH		14. MOTHER'S MAIDEN NAME MARIE STERGER		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES-KOREAN WAR	
16. SOCIAL SECURITY NO. 214228249		17. INFORMANT RECORDS BALTIMORE, MD 21229 ST AGNES HOSPITAL WILKENS & CATON AVE		18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) I METASTATIC CA SPINE & PROBABLY BRAIN CA LUNG ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from 11-14-19 69 to 12-22-19 69 that (X) (we) last saw the deceased alive on DECEMBER 22 19 69 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (X) (X) view the body after death.					
23A. SIGNATURE M. Cabiling				23B. DATE SIGNED 12/22/69	
23C. PHYSICIAN'S NAME (Type) M. CABILING				23D. ADDRESS BALTO MD 21229 ST AGNES HOSPITAL WILKENS & CATON AVES	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		12/26/69		Holy Rosary	
25A. DATE REC'D BY HEALTH DEPT. JAN 2 1970		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.		25C. FUNERAL DIRECTOR M. Stepanian	
25D. LOCATION (City, town, or county)		25E. ADDRESS		25F. ADDRESS	
Balto Co		6067 Harford Rd			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 69 13042	
1. NAME OF DECEASED (Type or Print) ALBERT M. MAYER		2. DATE AND HOUR OF DEATH 12-29-69 10:15 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 37 MERCY HOSP.		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Maryland B. COUNTY 2652			
		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 4826 Truesdale Ave 21206			
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/18/184	9. AGE (In years last birthday) 85
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Holla, Netherlands	
12. CITIZEN OF WHAT COUNTRY U.S.A.					
13. FATHER'S NAME Xaverius Mayer		14. MOTHER'S MAIDEN NAME Anna Spikman			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 215-09-3233-A		17. INFORMANT Mrs. H. Hooper ADDRESS 21206 4826 Truesdale Ave.	
18. 562.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshterio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Renal failure, respiratory failure DUE TO, OR AS A CONSEQUENCE OF: (B) Post op total colectomy DUE TO, OR AS A CONSEQUENCE OF: (C) for lower GI hemorrhage from diverticulitis - None other than advanced years			
19. DATE OF OPERATION 12/24/69		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Diverticulitis		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? (If in Baltimore City, give exact location)					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) No		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) -		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? -	
22. I certify that (I) (this hospital) attended the deceased from 12/21/69 19 69 to 12/29 19 69 and that (I) (we) last saw the deceased alive on 12/29 19 69 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Stanley Silber, M.D.		23B. DATE SIGNED 12/29/69			
23C. PHYSICIAN'S NAME (Type) Stanley Silber, M.D.		23D. ADDRESS Mercy Hospital BALT. MD.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/2/1970		24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery	
24D. LOCATION Belair Rd. Balto. Md. 21213					
25A. DATE REC'D BY HEALTH DEPT. JAN 2 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Seimonek Funeral Home ADDRESS 3331 Brehms Lane 21213	



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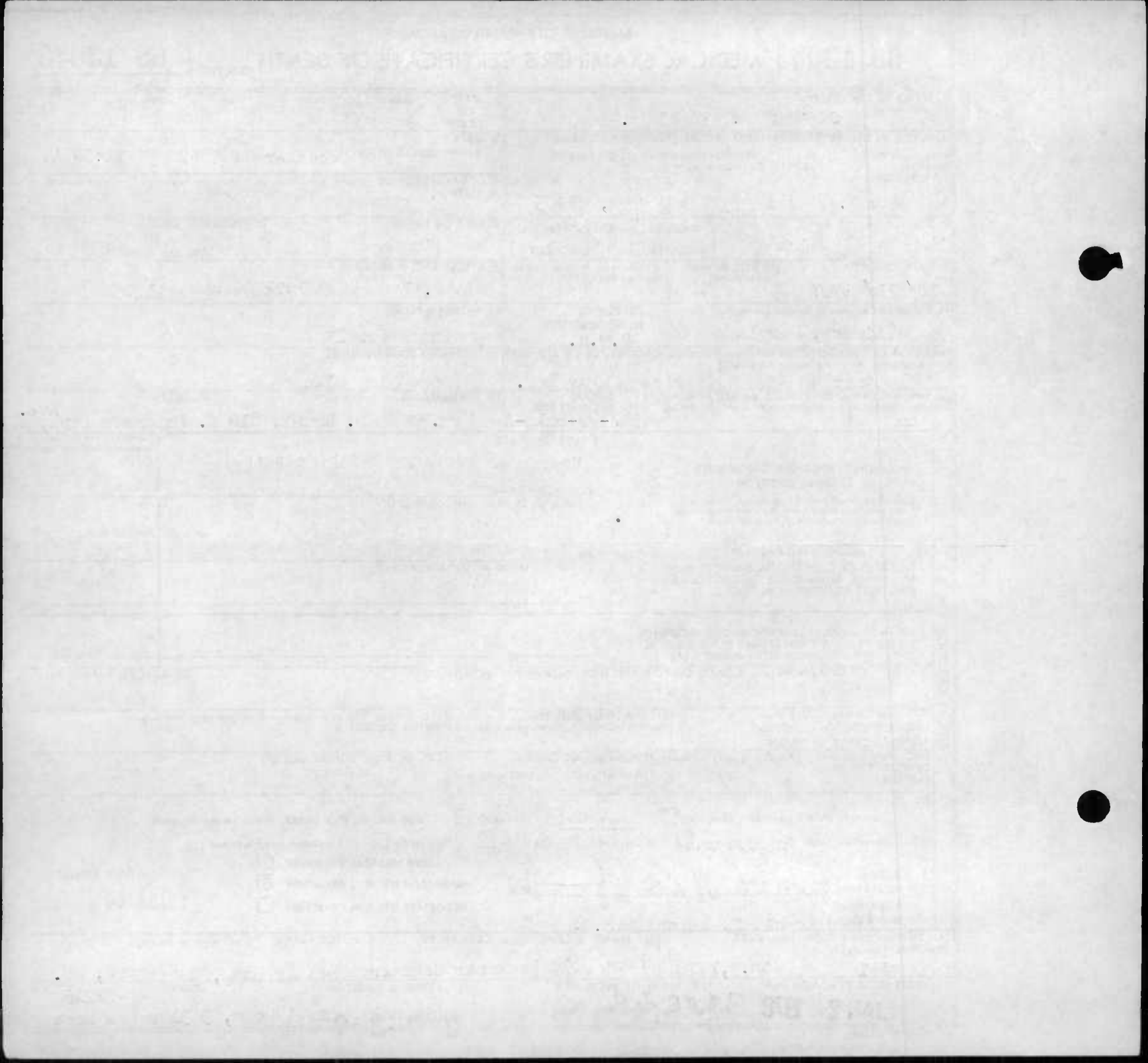
BALTIMORE CITY HEALTH DEPARTMENT

69 13043 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 13043

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JOSEPH F. KRUMI Sr.		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 816 N. Patterson Park Avenue, 21205		3. DATE PRONOUNCED DEAD Month Day Year Hour December 31, 1969 12:50 A.	
6. SEX Male		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 703	
9. DATE OF BIRTH 10/11/1907		10. AGE (In years last birthday) 62 If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank Krumi		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician	
15. MOTHER'S MAIDEN NAME Josephine Slechta		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no	
17. SOCIAL SECURITY NO. 212-09-6414-A		18. INFORMANT Mrs. Anna D. Krumi, 816 N. Paterson Park, Ave.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 141.9 1 Carcinoma of tongue with metastasis ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12/31/69			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Jan. 3, 1970	
24C. NAME OF CEMETERY or CREMATORY Most Holy Redeemer Cemetery		24D. LOCATION (City, town, or county) (State) Belair Road, Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 2 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Schimunek Funeral Home, 3331 Brehms Lane		ADDRESS 21213	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 13044 CERTIFICATE OF DEATH

REG. NO. 69 13044

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

BERTHA N. JOHNSON

2. DATE AND HOUR OF DEATH

DECEMBER 31, 1969 1:10 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

MONTEBELLO STATE HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

4638 HEATHFIELD ROAD 21212

5. SEX

Female

6. RACE

WHITE

7. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

2-3-1894

9. AGE (In years
last birthday)

75

If Under 1 Yr.
Months DaysIf Under 24 Hrs.
Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY

at home

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Henry

14. MOTHER'S MAIDEN NAME

Mary (nee Davern)

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

218-18-4174

17. INFORMANT

George Johnson son

ADDRESS

4501 Fullerton Ave. 21236

18. 412.41

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Cerebral Thrombosis

Left hemiplegia + aphasia

(B) A.S.C.V.D.

DUE TO, OR AS A CONSEQUENCE OF:

(C) Recurrent Urinary Tract Infection

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

Yrs

Yrs

Yrs

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

Recurrent Urinary Tract Infection

Yrs

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (H) (this hospital) attended the deceased from 9-12-1967 to 12-31-1969
that (I) (we) last saw the deceased alive on 12-30-1969 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Mohammad Inayatullah M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

12-31-1969

23C. PHYSICIAN'S
NAME (Type)

MOHAMMAD INAYATULLAH M.D.

23D. ADDRESS

MONTEBELLO HOSPITAL, BALTIMORE

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

1/3/1970

24C. NAME OF CEMETERY or CREMATORY

Louden Park Cemetery Co.

24D. LOCATION

(City, town, or county)

(State)

3801 Frederick Ave. Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

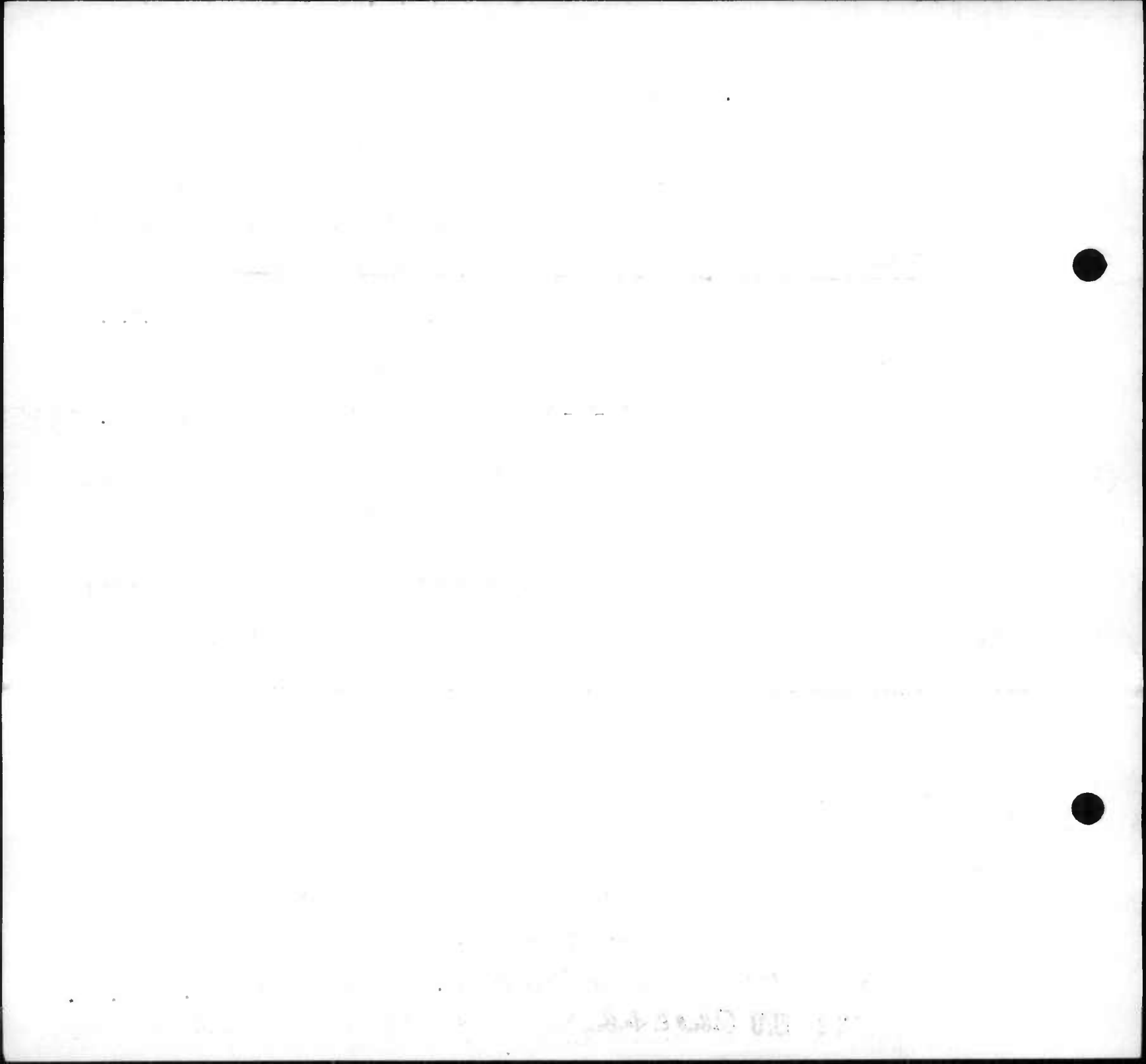
25C. FUNERAL DIRECTOR

ADDRESS

JAN 2 1970

Robert E. Taylor, M.D.

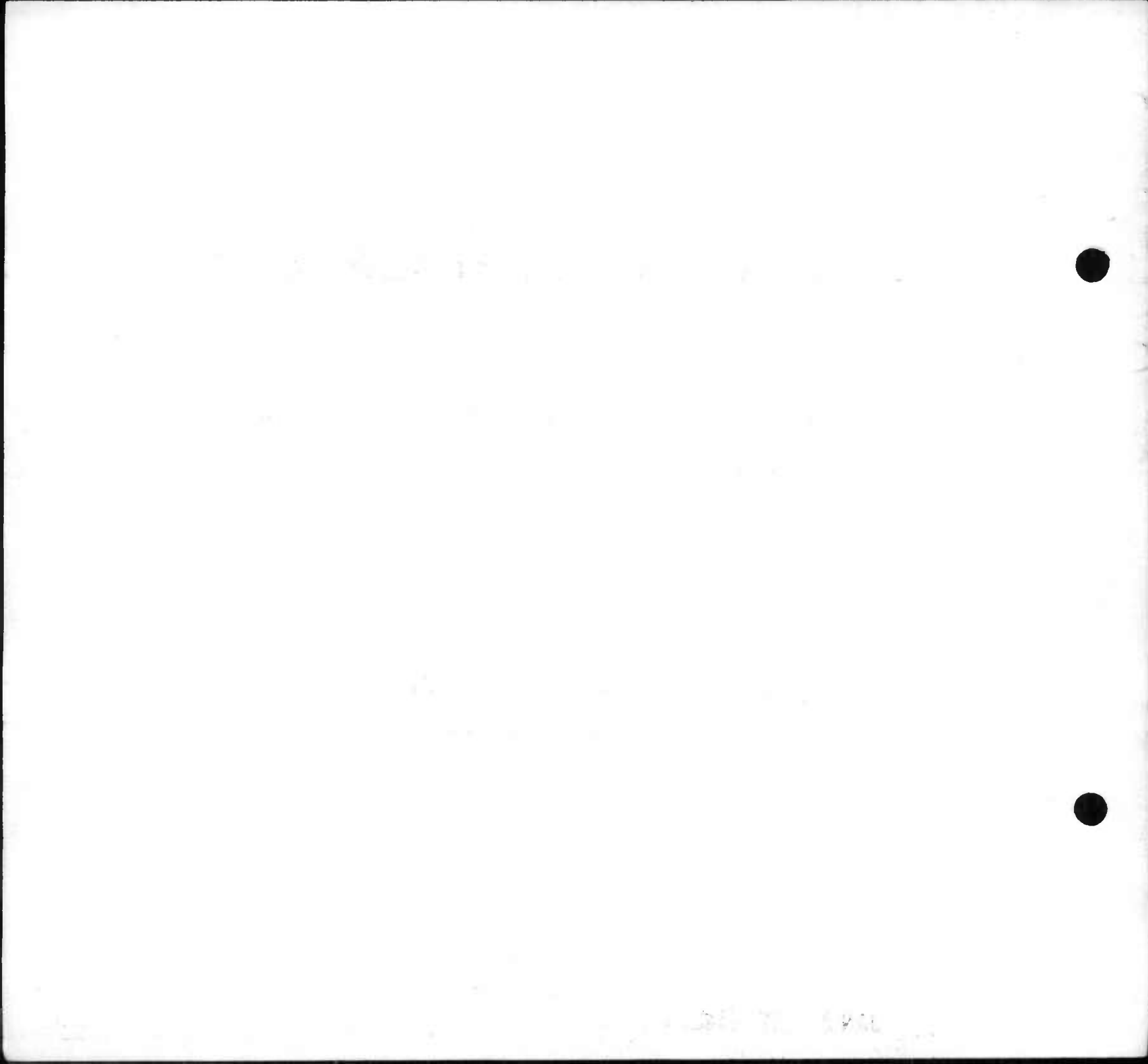
Schimmek Funeral Home 3331 Brehms Lane



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				69 13045		X		REG. NO. 69 13045	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) VELMA L. WELCH		2. DATE AND HOUR OF DEATH 7:30 AM 12/24/69 M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY WICOMICO		C. CITY OR TOWN SALISBURY D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNIVERSITY HOSPITAL 38				E. STREET AND NUMBER 123 CAROLYN AVE					
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEB. 17-1909		9. AGE (In years last birthday) 60		If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME WILLIAM HARRISON				14. MOTHER'S MAIDEN NAME JUNIA ABBOTT					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT LEO WELCH SR. 123 CAROLYN AV. SALISBURY MD. 21801			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 180 X I				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardio-respiratory failure (B) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF: Myocardial infarction (C) CARCINOMA OF CERVIX, RECURRENT					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
19A. DATE OF OPERATION 12/11/69				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CARCINOMA		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 11-24-69 19 to 12-24 19 69 that (I) (we) last saw the deceased alive on 11-24-69 19 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE David M. Cook				23B. DATE SIGNED 12/24/69		23C. PHYSICIAN'S NAME (Type) DEGREE			
23D. ADDRESS DEGREE				23E. ADDRESS					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12/29/69		24C. NAME of CEMETERY ST. JOHN'S CEMETERY		24D. LOCATION (City, town, or county) (State) DEAL ISLAND SOM MD			
25A. DATE REC'D BY HEALTH DEPT. JAN 2 1970		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR WEBSTER FUNERAL HOME					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

5-416 1

69 13046

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 69 13046

BIRTH NO.		1. NAME OF DECEASED (Type or Print) CARROLL SILVERBLATT		2. DATE AND HOUR OF DEATH Dec 30 1969 13:15 AM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2802		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SINAI HOSPITAL OF BALTIMORE 42			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER 5200 Fennell Ave					
5. SEX M	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/11/14	9. AGE (in years last birthday) 55
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Outlander		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTIMORE	
13. FATHER'S NAME Sam			14. MOTHER'S MAIDEN NAME Frieder		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT PATIENT ADDRESS 5200 Fennell Ave.	
18. 410.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Myocardial infarction massive			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
1. This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Acute Diverticulitis					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from Dec 24 19 69 to Dec 30 19 69 that (H) (we) last saw the deceased alive on Dec 30 19 69 and that (H) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE I. S. Gabriel 9054				23B. DATE SIGNED Dec 30, 1969	
23C. PHYSICIAN'S NAME (Type) I. S. AD GABRIEL JR				23D. ADDRESS SINAI HOSPITAL OF BALTIMORE	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/1/1970		24C. NAME OF CEMETERY or CREMATORY Liberty Park Cemetery	
24D. LOCATION (City, town, or county) (State) Randallstown Md					
25A. DATE REC'D BY HEALTH DEPT. JAN 2 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Pythian Lewis & Son 9610 Reisterstown Rd	

B5301

BALTIMORE CITY HEALTH DEPARTMENT

69 13047

CERTIFICATE OF DEATH

REG. NO.

69 13047

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

William M. Bennett, Sr.

2. DATE AND HOUR OF DEATH

12/28/69

6:30 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

00 140 S. Highland Avenue

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

Maryland

2608

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

140 S. Highland Avenue

5. SEX

M

6. RACE

W

7. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

12/5/96

9. AGE (In years
last birthday)

73

If Under 1 Yr.
Months DaysIf Under 24 Hrs.
Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Iron Worker

10B. KIND OF BUSINESS OR INDUSTRY

Bethlehem Steel

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Adam Bennett

14. MOTHER'S MAIDEN NAME

Catherine Broneker

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown)

yes

UN 7

16. SOCIAL
SECURITY NO.

273-07-6299

17. INFORMANT

Mrs. Bertha Bennett 140 S. Highland Ave.

ADDRESS

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Arteriosclerotic C.V. Dis.

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

5-10/1/1

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Dec. 5 1956 to 12/28/69 19
that (I) (we) last saw the deceased alive on Dec. 27 1969 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Benjamin H. Heston M.D.

DEGREE

Attending
Phys. ☒Med.
Director ☐Staff
Phys. ☐

23B. DATE SIGNED

12/29/69

23C. PHYSICIAN'S
NAME (Type)

DR. B. H. HESTON

DEGREE

23D. ADDRESS

121 S. HIGHLAND AVE BALTO. MD 21224

24A. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

12/31/69

24C. NAME OF CEMETERY or CREMATORY

Oak Lawn Cemetery

24D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

JAN 8 1970

25B. NAME OF REGISTRAR

John A. Moran, Inc.

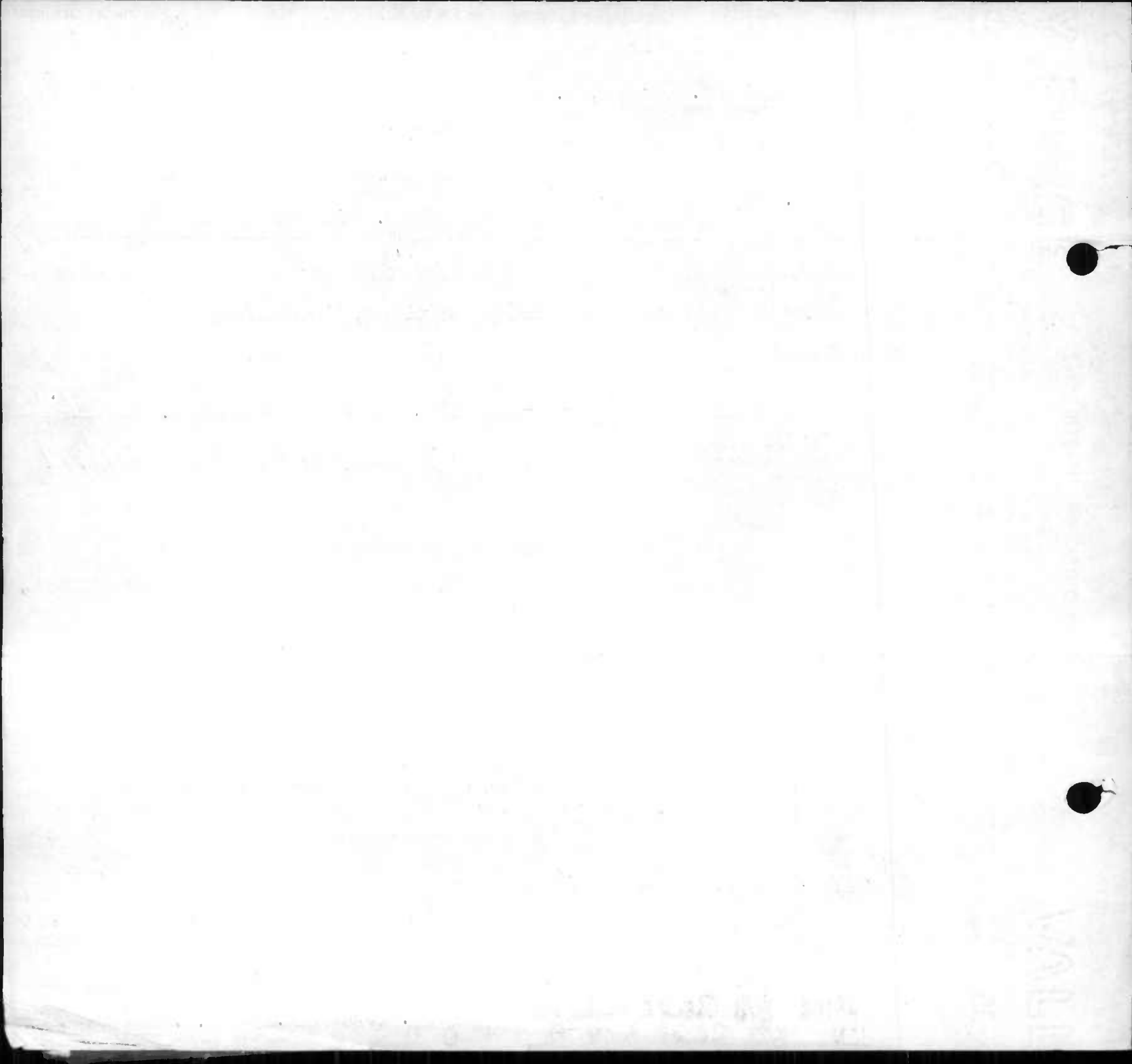
25C. FUNERAL DIRECTOR

John A. Moran, Inc. 3000 E. Baltimore St

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



69 13048 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 13048

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <u>Raley, George</u>				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <u>12</u> <u>27</u> <u>69</u> <u>11:50</u> <u>A.M.</u>			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>00 1156 Frailey Way</u> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				3. DATE PRONOUNCED DEAD Month Day Year Hour <u>12</u> <u>27</u> <u>69</u> <u>11:50</u> <u>A.M.</u>			
6. SEX <u>Male</u> 7. RACE <u>White</u> 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore City</u>		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH <u>SEPT. 1, 1916</u>		10. AGE (In years last birthday) <u>53</u>		11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CLARENCE RALEY</u>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		15. MOTHER'S MAIDEN NAME <u>BARBARA MCKENZIE</u>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>	
17. SOCIAL SECURITY NO. <u>212-10-6329</u>		18. INFORMANT <u>MRS. EDNA RALEY, BALTIMORE, MD.</u>		19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>Arteriosclerotic Cardiovascular Disease</u> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <u>412.41</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>1</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <u>0</u>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) <u>No</u>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>Ronald N. Kornblum</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <u>RONALD N. KORNBLUM MD</u> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>12-27-69</u> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>							
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>DEC. 31, 1969</u>		24C. NAME OF CEMETERY OR CREMATORY <u>FINZEL CEMETERY</u>		24D. LOCATION (City, town, or county) (State) <u>FINZEL, GARRETT, MD.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 2 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Farber, MD</u>		25C. FUNERAL DIRECTOR ADDRESS <u>JOSEPH R. DURST, FROSTBURG, MD. 21532</u>			

ABADIA, DAND

1940-1941

1940-1941

1940-1941

1940-1941

1

69 13049

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 13049

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

ROY D. COSTIGAN

2. DATE OF DEATH Known ☐ Month Day Year Hour
Estimated ☐ 12 28 69 1:27 a. M.4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

2634 N. Calvert St.

3. DATE PRONOUNCED DEAD Month Day Year Hour
December 28, 1969 1:27 a. M.5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

Maryland

B. COUNTY

6. SEX

Male

7. RACE

White

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

4/19/1942

10. AGE (In years last birthday)

27

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

2634 N. Calvert St.

11. BIRTHPLACE (State or foreign country)

Harrisonburg, Va.

12. CITIZEN OF

U.S.A.

13. FATHER'S NAME

Roy J. Costigan

14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

None

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Ara Correll

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL SECURITY NO.

219-38-9409

18. INFORMANT

Shirley P. Hollis

ADDRESS

904 Wellham Ave.

19.

E965X

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE Shotgun wound of the head
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

YES

22A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

Home

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

1st floor apt. 2634 N. Calvert St.

22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)

12 28 69 1:21 a.m.

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Subject shot during argument

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Ronald N. Kornblum, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/28/69

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

12/31/69

24C. NAME OF CEMETERY or CREMATORY

Glen Haven Memorial Pk. Glen Burnie, Md.

24D. LOCATION (City, town, or county) (State)

25A. DATE REC'D BY HEALTH DEPT.

JAN 2 1970

25B. NAME OF REGISTRAR

R. E. J. J. J. J.

25C. FUNERAL DIRECTOR

Raymond C. Fink

ADDRESS

Glen Burnie, Md.

1807

1807

1807

1807

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1807

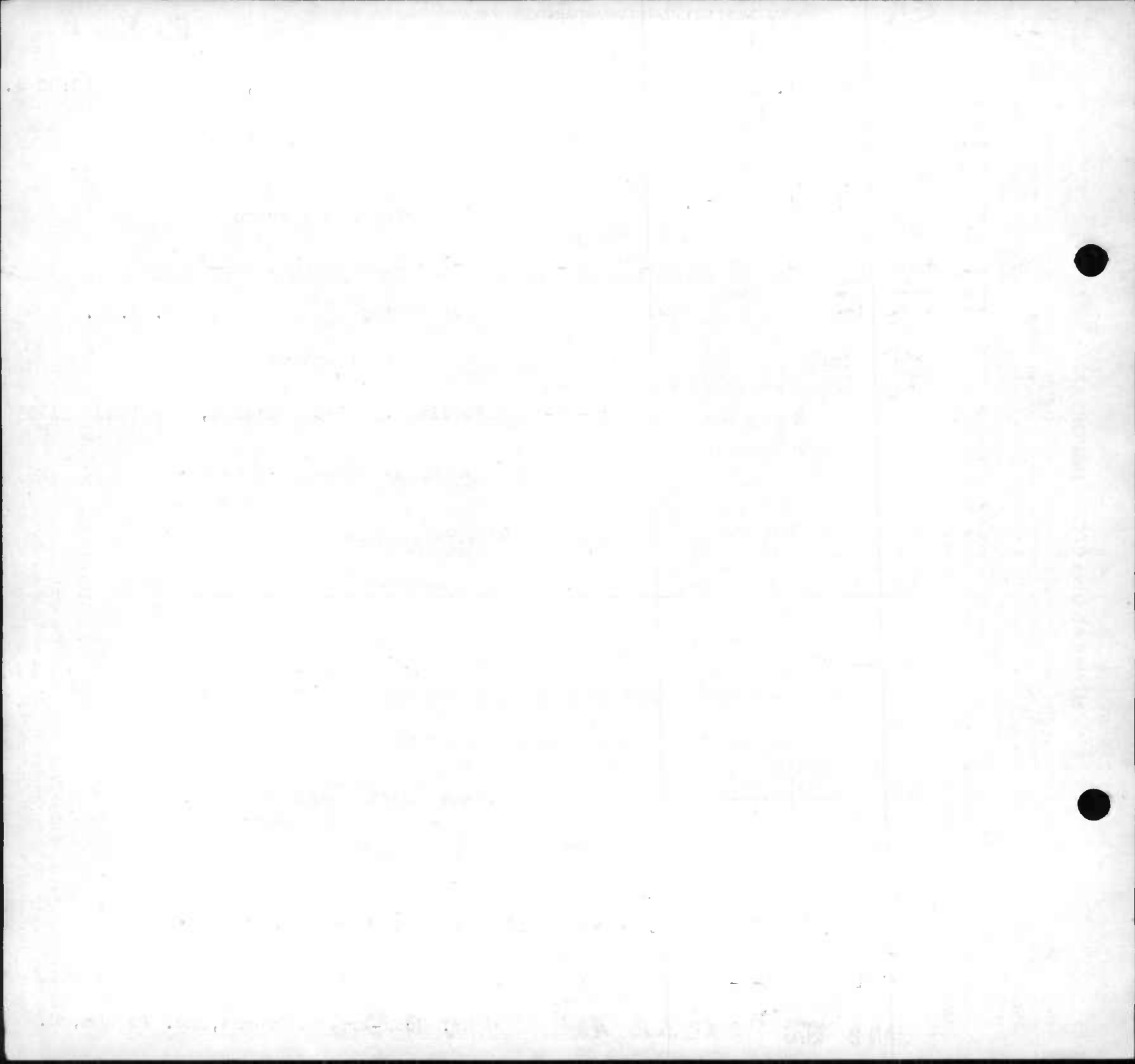
1807

1807

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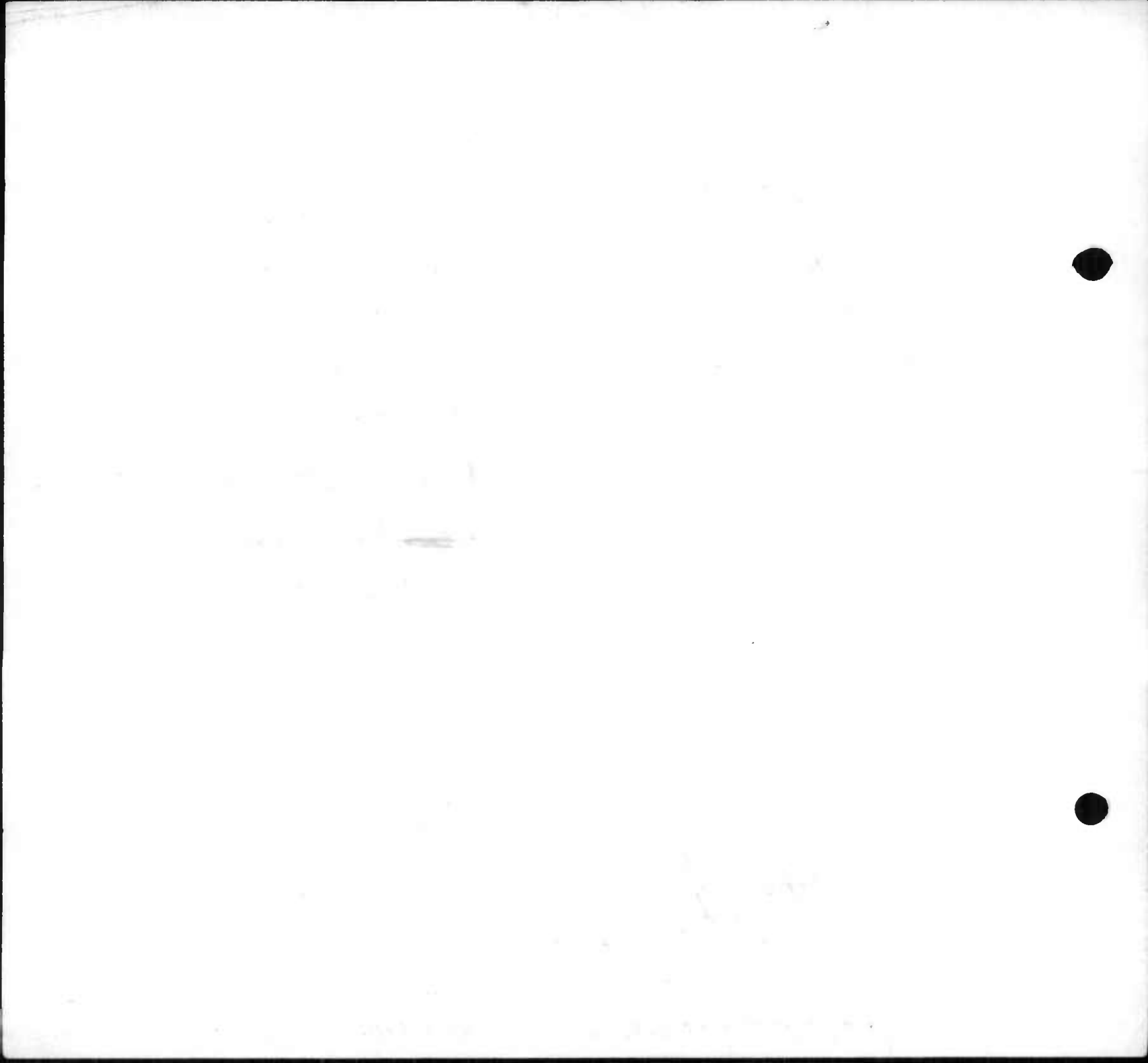
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 69 13050				BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO. 69 13050	
1. NAME OF DECEASED (Type or Print) AGNES E. CRIST				2. DATE AND HOUR OF DEATH December 30, 1969 10:00 A.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Pleasant Manor Nursing Home 4615 Park Heights Ave.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Towson D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 667 Bridgeman Terrace			
5. SEX Female	6. RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-17-98	9. AGE (In years lost birthday) 71	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Philip Brill				14. MOTHER'S MAIDEN NAME Mary Haunbaum			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 136-09-6868		17. INFORMANT ADDRESS Philip F. Crist Towson, Maryland 21204			
18. 4-12-21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Arterio Sclerotic Cardiovascular Disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Hypertension				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from JAN 29th 1968 to Nov 17th 1969 , that (I) (we) last saw the deceased alive on 11/17/1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.							
23A. SIGNATURE M. Kevin Quinn				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 12/30/69	
23C. PHYSICIAN'S NAME (Type) M. KEVIN QUINN MD				23D. ADDRESS 1927 York Rd, Timonium, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-2-70		24C. NAME OF CEMETERY or CREMATORY Rose Dale Cemetery		24D. LOCATION (City, town, or county) (State) Linden New Jersey	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS Wm Cook Brooks Towson, Inc. Towson, Md.			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO.	
69 13051				69 13051	
1. NAME OF DECEASED (Type or Print) <u>Emma Haven</u>		2. DATE AND HOUR OF DEATH <u>12/29/69</u> <u>1 7 30 P</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>University Hospital</u> <u>38</u>		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Ba</u> B. COUNTY <u>1803</u>			
		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>815 W Lombard</u>			
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/5/11</u>	9. AGE (In years last birthday) <u>58</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>S.C.</u>	
13. FATHER'S NAME <u>Lucius Smith</u>		14. MOTHER'S MAIDEN NAME <u>Ivory</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Husband</u>	
				ADDRESS <u>Same</u>	
18. <u>431.0</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Brain stem hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>hypertension</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>2 days</u> <u>years</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12/28</u> 19 <u>69</u> to <u>12/29</u> 19 <u>69</u> that (II) (we) last saw the deceased alive on <u>12/29</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Martin S Schwartz</u>		23B. DATE SIGNED <u>12/29/69</u>		23C. PHYSICIAN'S NAME (Type) <u>Martin S Schwartz</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/1/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Hickory Hill Cem.</u>	
24D. LOCATION <u>VARNSVILLE S.C.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 2 1970</u>		25B. NAME OF REGISTRAR <u>W. D. MARCH</u>	
25C. FUNERAL DIRECTOR <u>928 E North Ave</u>		25D. ADDRESS		25E. ADDRESS	



S-530

FUNERAL DIRECTOR: IMPORTANT

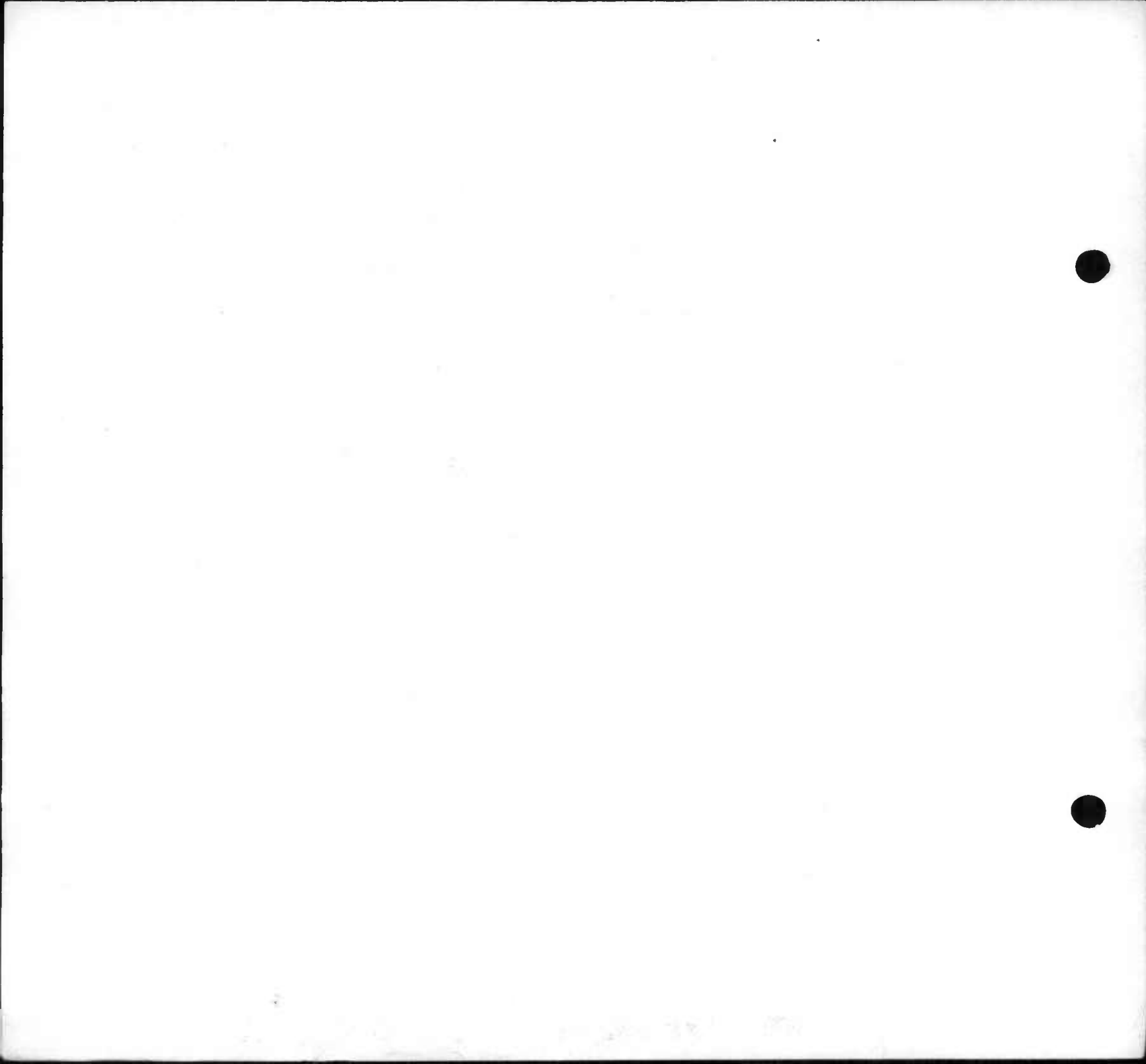
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 13052	
CERTIFICATE OF DEATH			
BIRTH NO. 69 13052		2. DATE AND HOUR OF DEATH 12-31-69 4:45 P.M.	
1. NAME OF DECEASED (Type or Print) SMITH, EUGENE		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 908	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 31 Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Md. 21224		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Male 6. RACE Negro		E. STREET AND NUMBER 923 Bonaparte Ave. Baltimore, Md. 21212 007	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-14-24 9. AGE (in years last birthday) 45	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Kitchen Help		11. BIRTHPLACE (State or foreign country) South Carolina 12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Guy Smith		14. MOTHER'S MAIDEN NAME Anna BRADLY	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 248-20-3081	
17. INFORMANT BCH Records: 4940 Eastern Ave, Baltimore, Md. 21224		ADDRESS	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTecedent CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Cerebral Hematoma		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-24 1969 to 12-31 1969 that (I) (we) last saw the deceased alive on 12-31 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE J. R. Wands M.D.		23B. DATE SIGNED 12/31/69	
23C. PHYSICIAN'S NAME (Type) J. R. Wands M.D.		23D. ADDRESS Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Md. 21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/5/70	
24C. NAME of CEMETERY or CREMATORY BALTO NATIONAL CEM		24D. LOCATION (City, town, or county) (State) BALTO. MD.	
25A. DATE REC'D BY HEALTH DEPT. JAN 2 1970		25B. NAME OF REGISTRAR Paul E. J. J. J.	
25C. FUNERAL DIRECTOR Wm. J. J. J.		ADDRESS 928 E NORTH AVE	

SMITH, EUGENE

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

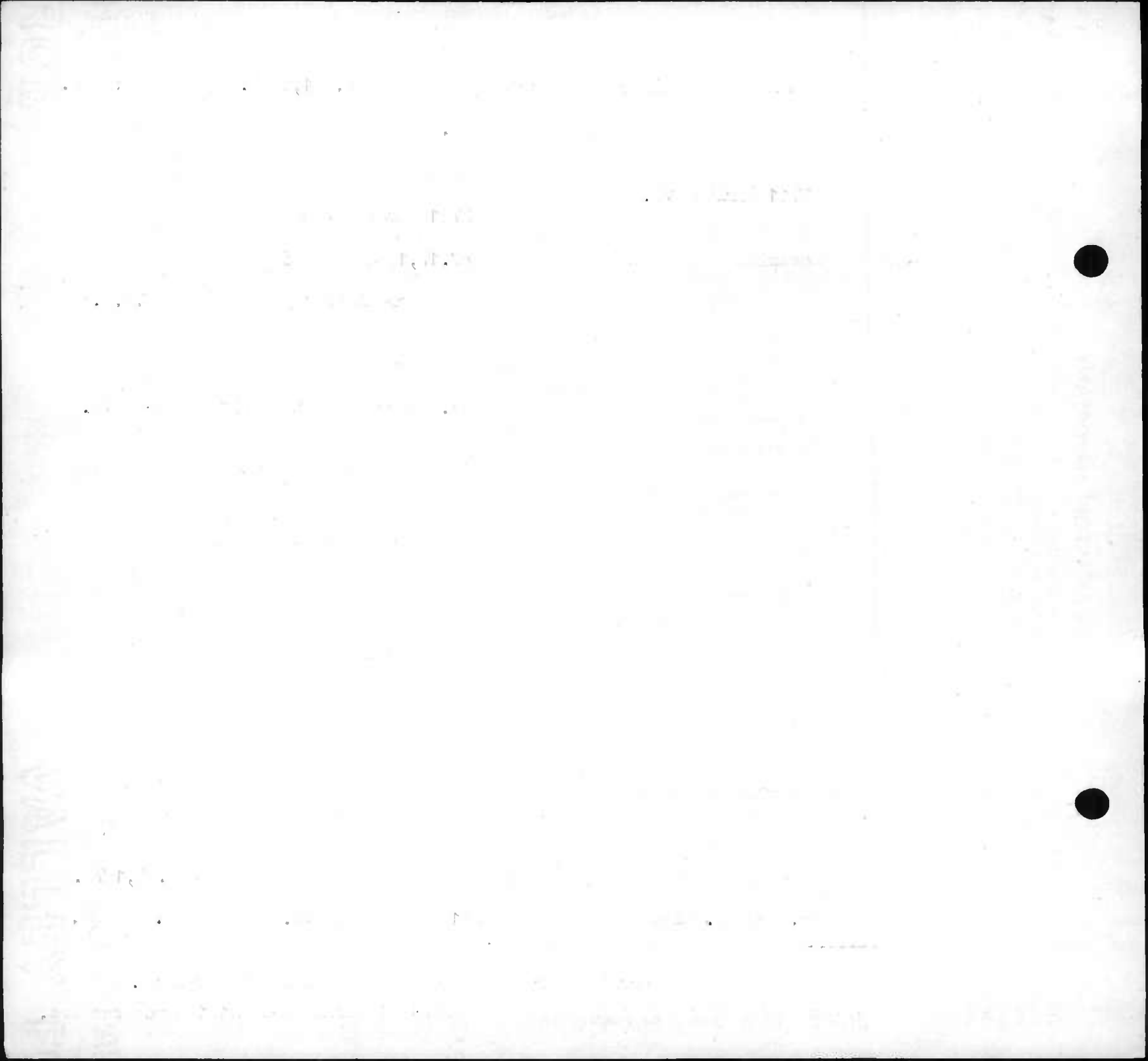
BALTIMORE CITY HEALTH DEPARTMENT		69 13053		CERTIFICATE OF DEATH		X REG. NO. 69 13053	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <u>HOWARD R. MURRAY</u>			
2. DATE AND HOUR OF DEATH <u>12-29-69</u> <u>8:00 P.M.</u>							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>BON SECOURS HOSPITAL</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>BON SECOURS HOSPITAL</u>				C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
E. STREET AND NUMBER <u>1915 CLIFDEN ROAD</u>							
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-17-96</u>	9. AGE (in years last birthday) <u>73</u>	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Post Office</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ELIJAH MURRAY</u>				14. MOTHER'S MAIDEN NAME <u>MARY MARSHALL</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Miss Alice Murray, 1915 Clifden Road, 21228</u>		ADDRESS	
18. <u>412.4 I</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE <u>Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Arteriosclerotic Cardio-</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Vascular Disease</u> (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <u>10-6-69</u> 19 to <u>12-29</u> 19 <u>69</u> that (1) (we) last saw the deceased alive on <u>12-29</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>A.S. LALANI</u>				23B. DATE SIGNED <u>12-29-69</u>			
23C. PHYSICIAN'S NAME (Type) <u>A.S. LALANI, M.D.</u>				23D. ADDRESS <u>BON SECOURS HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/2/70</u>		24C. NAME of CEMETERY or CREMATORY <u>Crestlawn Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Carroll Cty, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 2 1970</u>		25B. NAME OF REGISTRAR <u>Bob E. Jaber, M.D.</u>		25C. FUNERAL DIRECTOR <u>1630</u>		ADDRESS <u>1630</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 13054	
69 13054				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Roland Kaiser Zentz		Dec. 31, 1969. 9:30 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
00 2711 Harlem Ave.				Md. Baltimore	
				C. CITY OR TOWN D. INSIDE CITY LIMITS?	
				Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER	
				2711 Harlem Avenue	
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Male	Caucasian	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	Nov. 17, 1884	85	Retired
11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
Carroll County			U.S.A.		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Aaron Zentz			Margaret		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				Mrs. Gertrude Zentz 3314 Dudley Ave.	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
I 410.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) CORONARY ARTERY OCCLUSION Anterograde Cardio Vasc. Disease				sudden	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes No)	
0				no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 1-9-1959 to 12-31-1969, that (I) (we) last saw the deceased alive on 7-22-1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. cleared & medical examiner					
23A. SIGNATURE				23B. DATE SIGNED	
Dr. Harry L. Knipp				Jan. 2, 1970.	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Dr. Harry L. Knipp		4116 Edmondson Ave.		Balto. Md.	
24A. BURIAL REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		1/5/70		Lorraine Park Cemetery	
				Baltimore Maryland.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JAN 2 1970		Robert E. Fisher, R.D.		Witzke Funeral Home 4101 Edmondson Ave.	

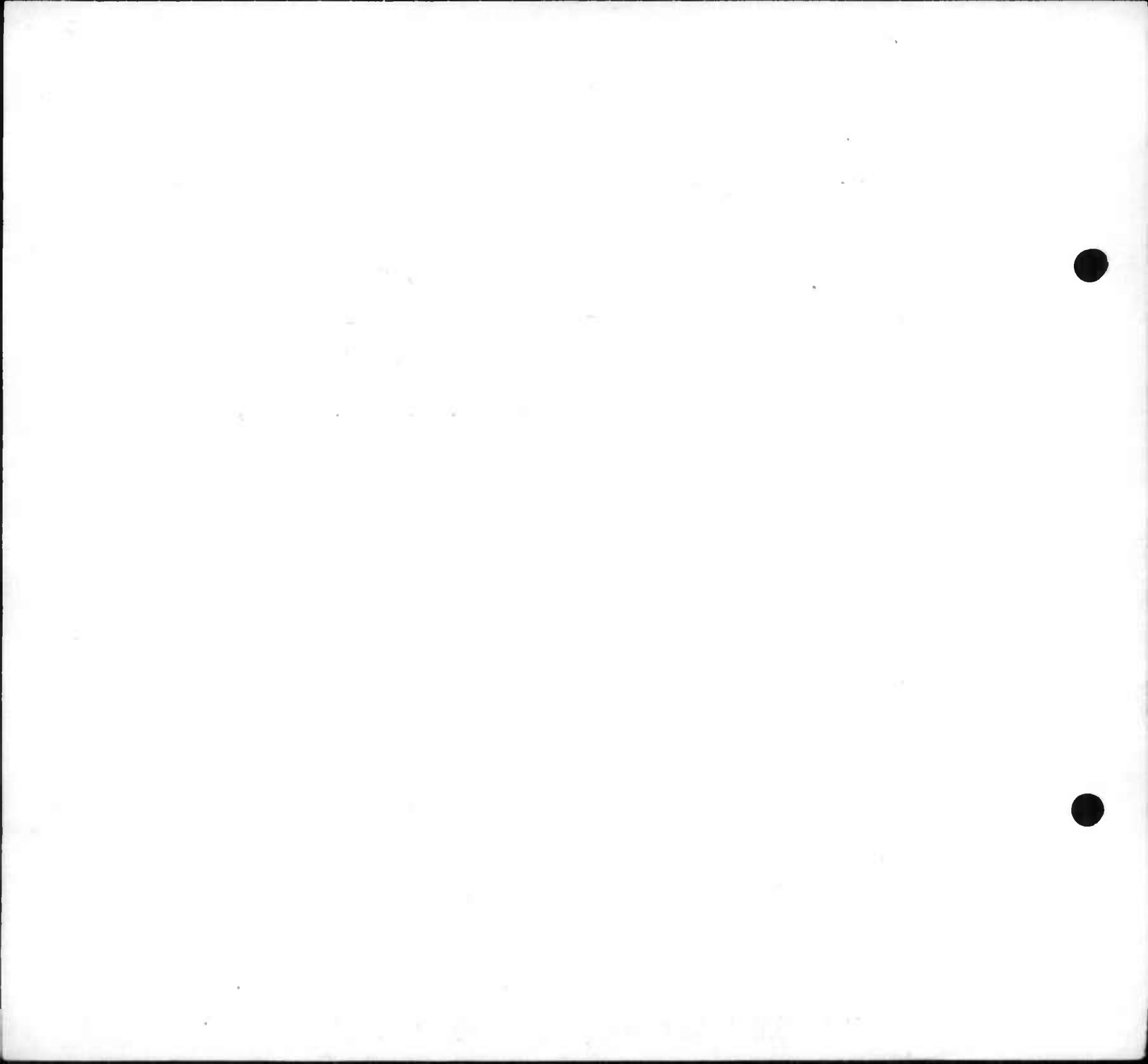


This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 69 13055 CERTIFICATE OF DEATH

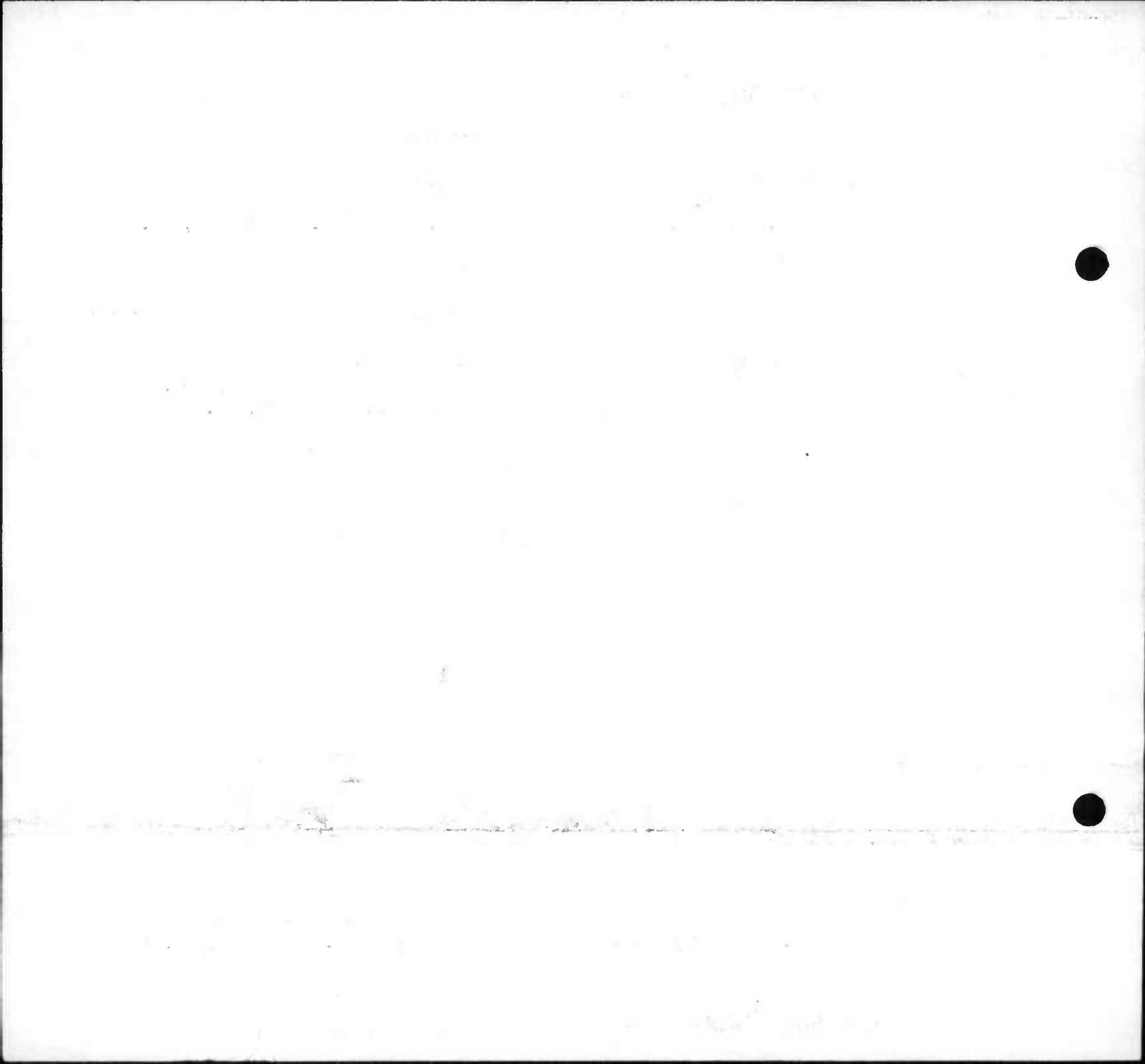
REG. NO. 69 13055

BIRTH NO. 69 13055		2. DATE AND HOUR OF DEATH Dec. 30 th 1969 9:45 A.M.	
1. NAME OF DECEASED (Type or Print) WILLIAM YOUNKER		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 35 CHURCH HOME AND HOSPITAL 100 NORTH BROADWAY BALTIMORE, MARYLAND 21231	
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 2854 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 21229		5. SEX male 6. RACE WHITE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH JULY 27, 1900 9. AGE (in years last birthday) 69	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Printer		10B. KIND OF BUSINESS OR INDUSTRY PAINTER-RETIRED	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13. FATHER'S NAME WILLIAM YOUNKER		14. MOTHER'S MAIDEN NAME MARIE STOLB	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service no		16. SOCIAL SECURITY NO. 212 07 3586	
17. INFORMANT Mrs. William F. Younker, 836 Stamford Road		ADDRESS	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Hemorrhage from Splenic Artery, Hypertension, Pancreatitis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days	
19A. DATE OF OPERATION 12/28/69		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Acute Abdomen Hemorrhage from Splenic Artery	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Dec 27 th 1969 to Dec 30 th 1969 that (I) (we) last saw the deceased alive on Dec 30 th 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE A Jbyan		23B. DATE SIGNED Dec 30 th 1969	
23C. PHYSICIAN'S NAME (Type) A Jbyan		23D. ADDRESS Church Home and Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/2/70	
24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 2 1970		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Witzke		25D. ADDRESS 1630 Edmondson Ave. Catonsville	



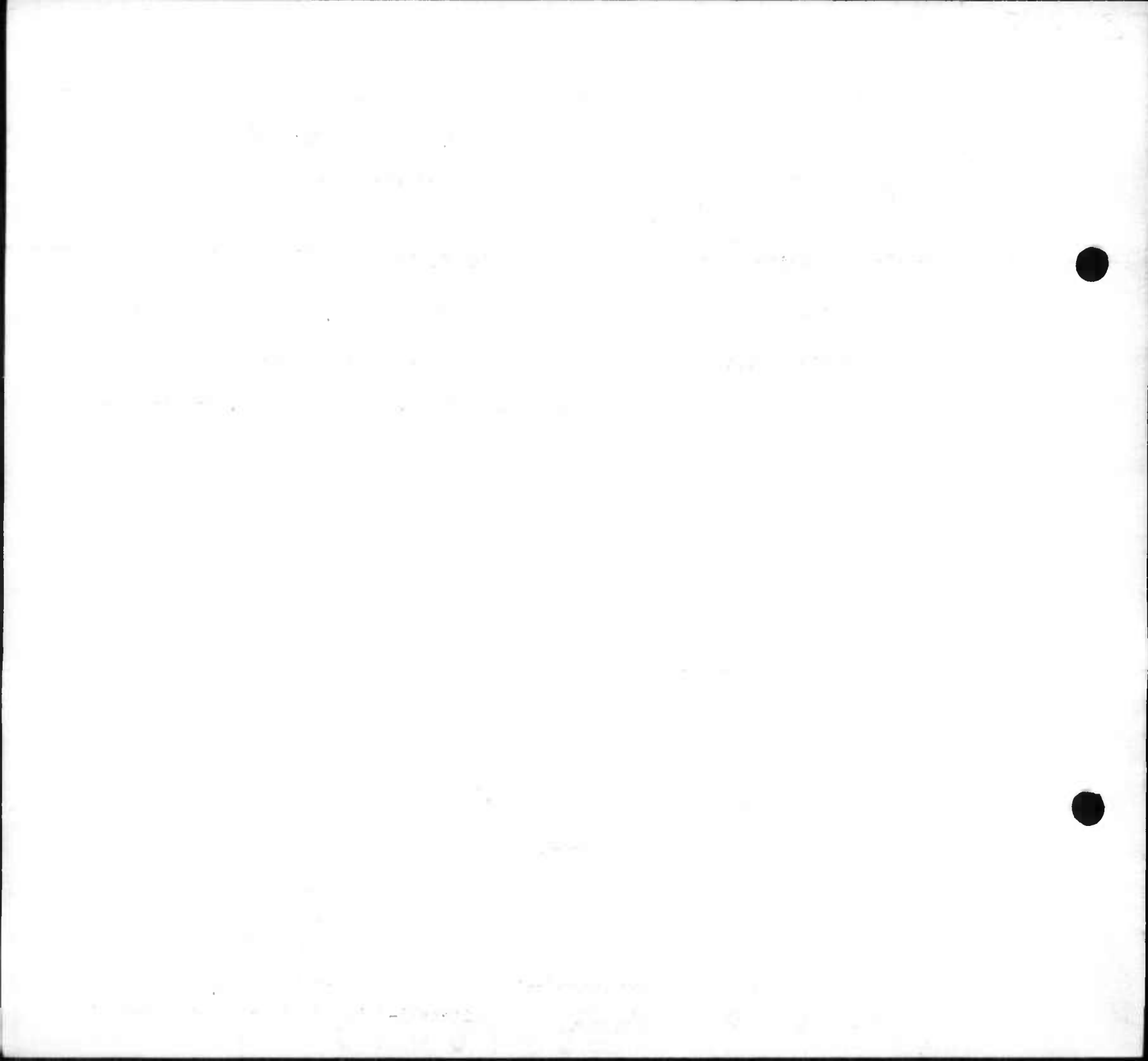
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

56-01-20 csk		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 13056	
BIRTH NO. 69 13056		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Booth Jr, John			2. DATE AND HOUR OF DEATH DEC. 30, 1969 7:15 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 31 Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Md. 21224			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Maryland B. COUNTY 704		
5. SEX Male		6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-3-27
9. AGE (In years last birthday) 42		10. UNDER 1 Yr. Months: Days: Hours: Min.		11. BIRTHPLACE (State or foreign country) Maryland	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John Booth			14. MOTHER'S MAIDEN NAME Louise Holliman		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 220-18-5702		17. INFORMANT BCH Records: Baltimore, Md. 21224	
18. I 162.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Constrictive PERICARDITIS ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) Metastases from Carcinoma Lung DUE TO, OR AS A CONSEQUENCE OF: (C) Carcinoma lung			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 mo 1 yr.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from DEC 27 19 69 to DEC 30 19 69 that (I) (we) last saw the deceased alive on Dec 30 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dale N. Schumacher M.D.			23B. DATE SIGNED 12/30/69		23C. PHYSICIAN'S NAME (Type) Dale N. Schumacher M.D.
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 1-3-1970		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			25A. DATE REC'D BY HEALTH DEPT. JAN 2 1970		
25B. NAME OF REGISTRAR Robert E. Taylor, R.D.			25C. FUNERAL DIRECTOR Marshall W. Jones, Jr.		



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

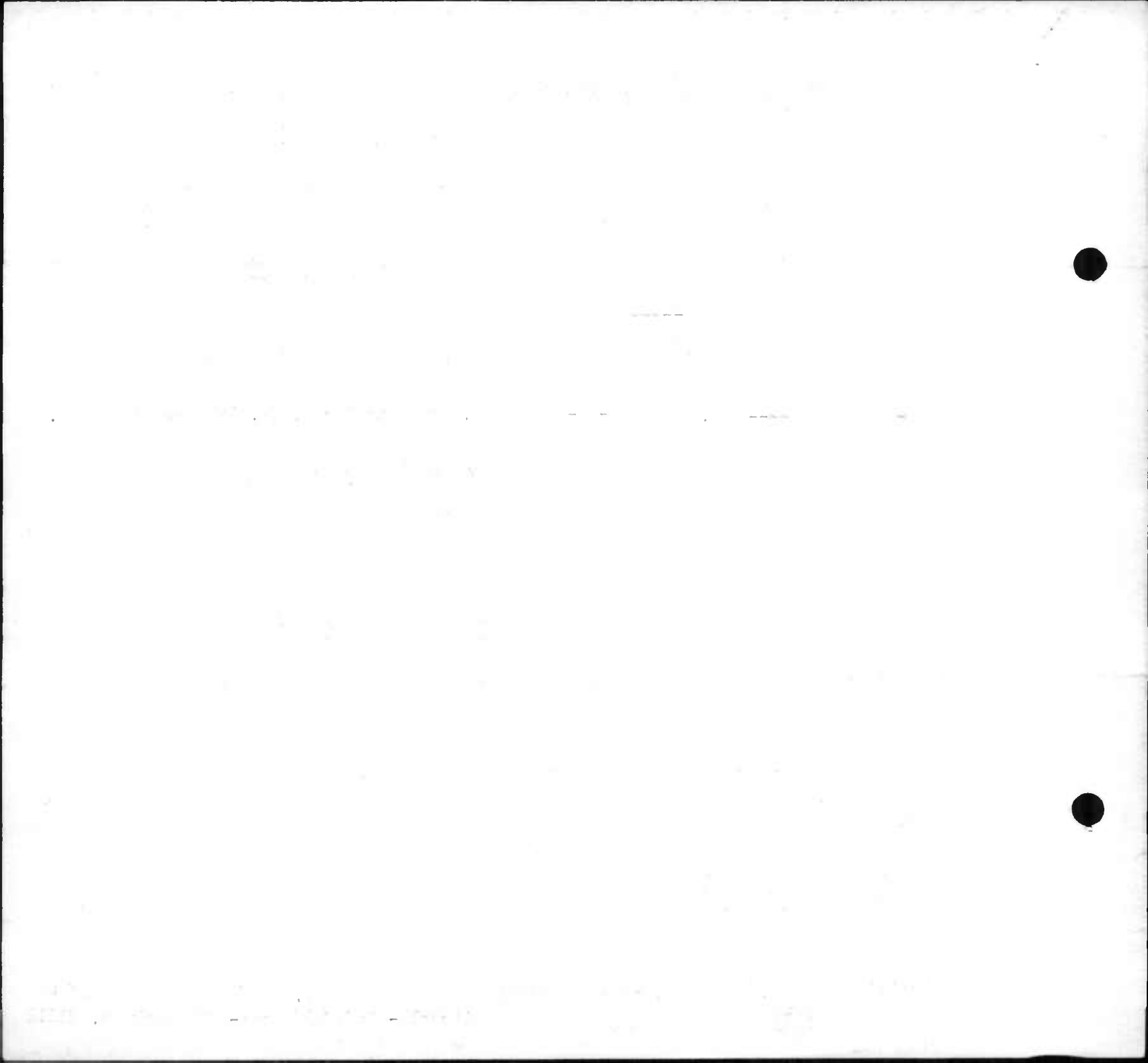
69 13057		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 69 13057
BIRTH NO.				
1. NAME OF DECEASED (Type or Print) MADELINE A. CALLANAN			2. DATE AND HOUR OF DEATH 12-29-69 1:35 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 37 Mercy Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore 5300	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 37 Mercy Hospital			C. CITY OR TOWN Rodgers Forge D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
			E. STREET AND NUMBER 603 Murdock Road	
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 9, 1903	9. AGE (In years last birthday) 66
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Baltimore Md.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Patrick Moylan			14. MOTHER'S MAIDEN NAME Mary Veronica Kearney	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 220-44-1719	17. INFORMANT Gerard J. Callanan 314 E. Melrose Ave	
18. CAUSE OF DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardiorespiratory Failure				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Carcinoma of Pancreas with diffuse abdominal metastasis				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (X) (this hospital) attended the deceased from 12/14 19 69 to 12-29 19 69 that (X) (we) last saw the deceased alive on 12-29 19 69 and that (X) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (X) (did) (did not) view the body after death.				
23A. SIGNATURE Randhir P. Sinha M.B.B.S., M.D.			23B. DATE SIGNED 12-29-69	
23C. PHYSICIAN'S NAME (Type) RANDHIR PRASAD SINHA M.B.B.S., M.D.			23D. ADDRESS Mercy Hospital, Balto, Md. 21202	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 12/31/69	24C. NAME OF CEMETERY OR CREMATORY New Cathedral		24D. LOCATION (City, town, or county) (State) Baltimore Md.
25A. DATE REC'D BY HEALTH DEPT. JAN 2 1970		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR Mitchell-Wiedefeld Home 6500 York Rd



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		69 13058		CERTIFICATE OF DEATH		REG. NO. 69 13058	
BIRTH NO. 69 13058				1. NAME OF DECEASED (Type or Print) <i>Angela T. Kohlhepp</i>			
2. DATE AND HOUR OF DEATH <i>12-31-69 1130/A.</i>				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>37 MERCY HOSPITAL</i>				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>2748</i>			
C. CITY OR TOWN <i>BALTIMORE</i>				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER <i>1147 E. NORTHERN PKWY</i>				5. SEX <i>FEMALE</i> 6. RACE <i>WHITE</i> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <i>12-17-96</i> 9. AGE (in years last birthday) <i>73</i>				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i>			
11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>				12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>FRANCIS TORMEY</i>				14. MOTHER'S MAIDEN NAME <i>MARY HEWISLER</i>			
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no-</i>				16. SOCIAL SECURITY NO. <i>159-07-3417 B</i>			
17. INFORMANT <i>Mr. Harry Kohlhepp, Sr.</i>				ADDRESS <i>1147 Northern Pkwy.</i>			
18. <i>43391-2509</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE <i>Acute Cerebral Thrombosis</i>			
ANTECEDENT CAUSES				DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) _____			
(C) _____				II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>Diabetes mellitus</i>			
19A. DATE OF OPERATION <i>None</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> (If yes, medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>12-31</i> 19 <i>69</i> to <i>12-31</i> 19 <i>69</i> that (I) (we) last saw the deceased alive on <i>12-31</i> 19 <i>69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>C. S. R. F. L.</i>				23B. DATE SIGNED <i>12-31-69</i>		23C. PHYSICIAN'S NAME (Type) <i>C. E. D. F. L. L. C. 2</i>	
23D. ADDRESS				23E. FUNERAL DIRECTOR <i>Mitchell-Wiedefeld Home</i>		ADDRESS <i>6500 York Rd. 21212</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1/3/70</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Cathedral Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Balto. MD.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 2 1970</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>		25C. FUNERAL DIRECTOR		ADDRESS	



6-6501

BALTIMORE CITY HEALTH DEPARTMENT

69 13059

CERTIFICATE OF DEATH

REG. NO.

69 13059

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

MELVIN A. GRAHAM

2. DATE AND HOUR OF DEATH

12/31/69

3:15 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

44 Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE

MD

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

633 E. 33rd St

5. SEX

M

6. RACE

W

7. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

11/26/1917

9. AGE (in years
last birthday)

78

If Under 1 Yr.

Months Days

If Under 24 Hrs.

Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

RETIRED

10B. KIND OF BUSINESS OR INDUSTRY

SOUTHERN-BEEF CO.

11. BIRTHPLACE (State or foreign country)

MD

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Thomas H. Graham

14. MOTHER'S MAIDEN NAME

Catherine Heim

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

WWI

16. SOCIAL
SECURITY NO.

215-010417

17. INFORMANT

Anna E. Graham

ADDRESS

Same

18. 429.01

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

21E. INJURY OCCURRED

While At ☐

Work

Not While ☐

At Work

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12/26/1969 to 12/31/1969
that (I) (we) last saw the deceased alive on 12/31/1969 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Dr. Ronald V. Gehler

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

12/31/69

23C. PHYSICIAN'S
NAME (Type)

23D. ADDRESS

Union Memorial Hospital

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

1-3-70

24C. NAME OF CEMETERY or CREMATORY

Oaklawn Cemetery

24D. LOCATION

Baltimore County,

(City, town, or county)

(State)

Md.

25A. DATE REC'D BY HEALTH DEPT.

JAN 2 1970

25B. NAME OF REGISTRAR

H. W. Jenkins, M.D.

25C. FUNERAL DIRECTOR

H. W. Jenkins Sons Co. 4905 York Rd.
Balto., Md. 21212

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-1301

69 13060

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

69 13060

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Col. Delphin Thebaud

2. DATE AND HOUR OF DEATH

12-31-69 1:15 AM

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

34 Bon Secours Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☐NO ☐

E. STREET AND NUMBER

114 West University Parkway

5. SEX

M

6. RACE

W

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

12-23-89

9. AGE (In years
last birthday)

80

If Under 1 Yr.

Months

Days

If Under 24 Hrs.

Hours

Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

RETIRED-OFFICER U.S. ARMY

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

CALIFORNIA

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

JOSEPH V. Thebaud

14. MOTHER'S MAIDEN NAME

MARIE KUPENSHANK

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

YES

WWT & WWT

16. SOCIAL
SECURITY NO.

213-28-6937

17. INFORMANT

H. CHART

ADDRESS

MRS ESTHER C. THEBAUD
(SAME)

18.

412.31

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

Arterio-sclerotic Heart Disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

YEARS

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (Notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11/28 1969 to 12/31 1969
that (I) (we) last saw the deceased alive on 12/31 1969 and that (I) (we) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did not) view the body after death.

23A. SIGNATURE

M. Abbas M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

12-31-69

23C. PHYSICIAN'S
NAME (Type)

M. Abbas M.D.

23D. ADDRESS

Bon Secours Hosp.

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

1/3/70

24C. NAME OF CEMETERY or CREMATORY

New Cathedral

24D. LOCATION

Baltimore,

(City, town, or county)

(State)

Md.

25A. DATE REC'D BY HEALTH DEPT.

JAN 2 1970

25B. NAME OF REGISTRAR

B. E. Tabor, M.D.

25C. FUNERAL DIRECTOR

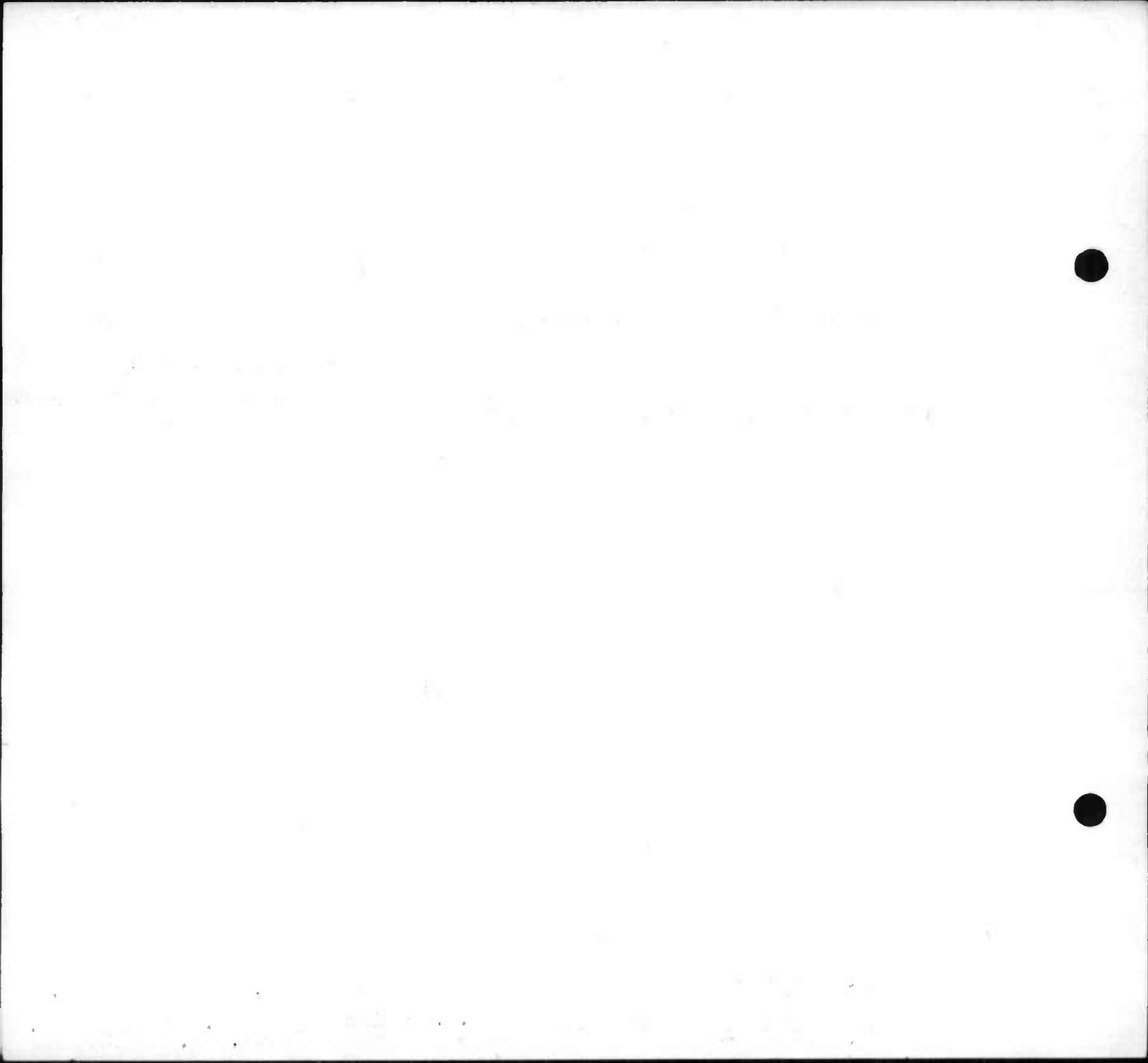
H. W. Jenkins & Sons Co. 4905 York Rd.

ADDRESS

Balto. Md. 21212

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-6231

69 13061

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

69 13061

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Wright, Miss Alice V.

2. DATE AND HOUR OF DEATH

12-31-69

9:15am

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Keswick Home
700 West 40th Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

3501 St Paul Street

5. SEX

F

6. RACE

W

7. MARRIED ☐

NEVER MARRIED ☒

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

2-27-94

9. AGE (In years last birthday)

75

11 Under 1 Yr. Months: Days

11 Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Nurse

10B. KIND OF BUSINESS OR INDUSTRY

Hospital

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Robert A. Wright

14. MOTHER'S MAIDEN NAME

Alice V. Willhide

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)
no

16. SOCIAL SECURITY NO.

219-30-7438

17. INFORMANT

Keswick Medical Records

ADDRESS

18. 412.31

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B) ASCVD with left hemiplegia

DUE TO, OR AS A CONSEQUENCE OF:

(C) Myocardial Infarction

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

3 days

2 yrs

3 yrs

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 10 Dec 1968 to 31 Dec 1969, that (I) (we) last saw the deceased alive on 31 Dec 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

A. Richardson M.D.

Attending Phys. ☐

Med. Director ☒

Staff Phys. ☐

23B. DATE SIGNED

31 Dec 1969

23C. PHYSICIAN'S NAME (Type)

A. Richardson M.D.

23D. ADDRESS

Keswick Home

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

1/2/69

24C. NAME OF CEMETERY or CREMATORY

Baltimore

24D. LOCATION

(City, town, or county)

Baltimore,

Md.

25A. DATE REC'D BY HEALTH DEPT.

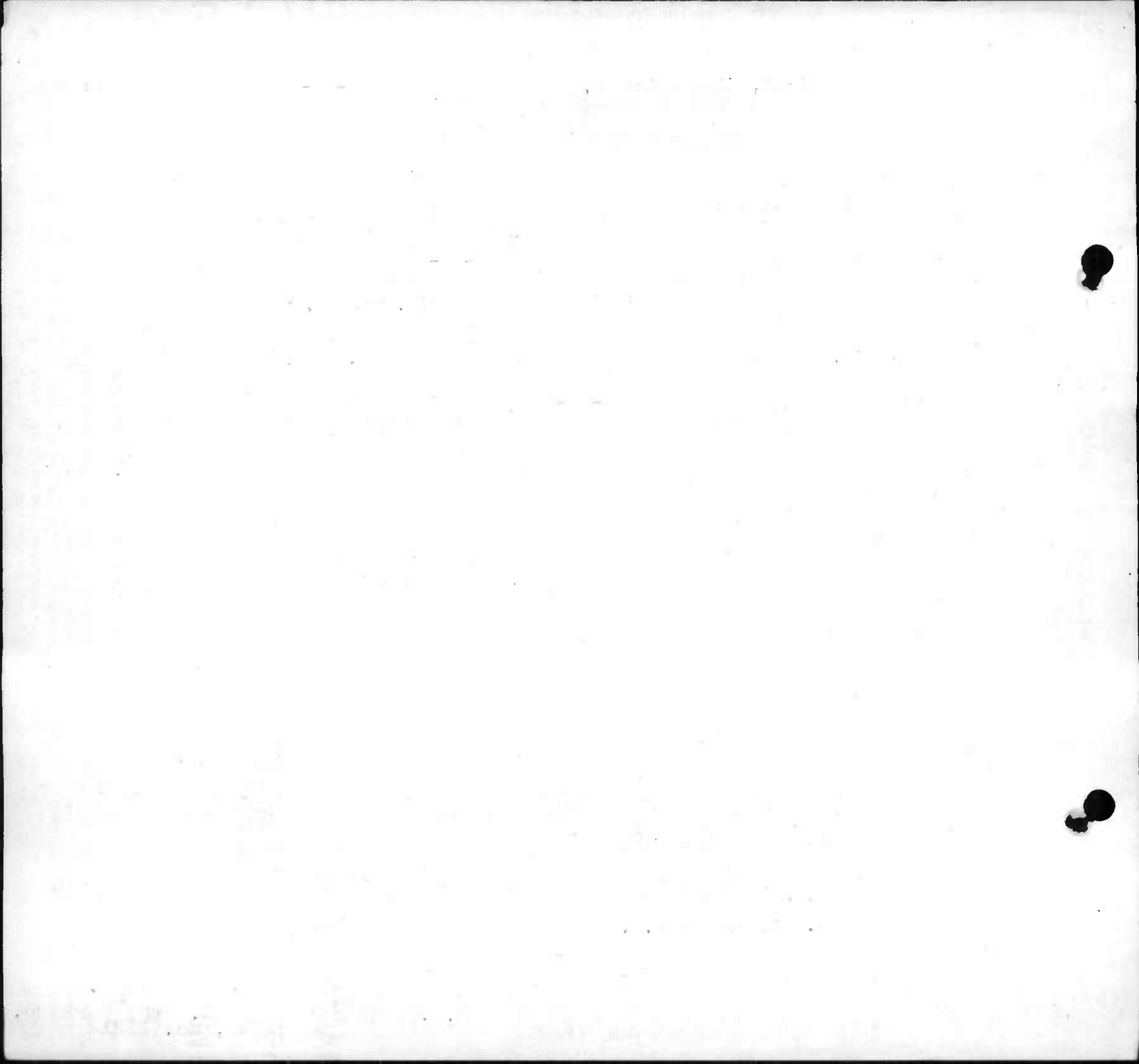
25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

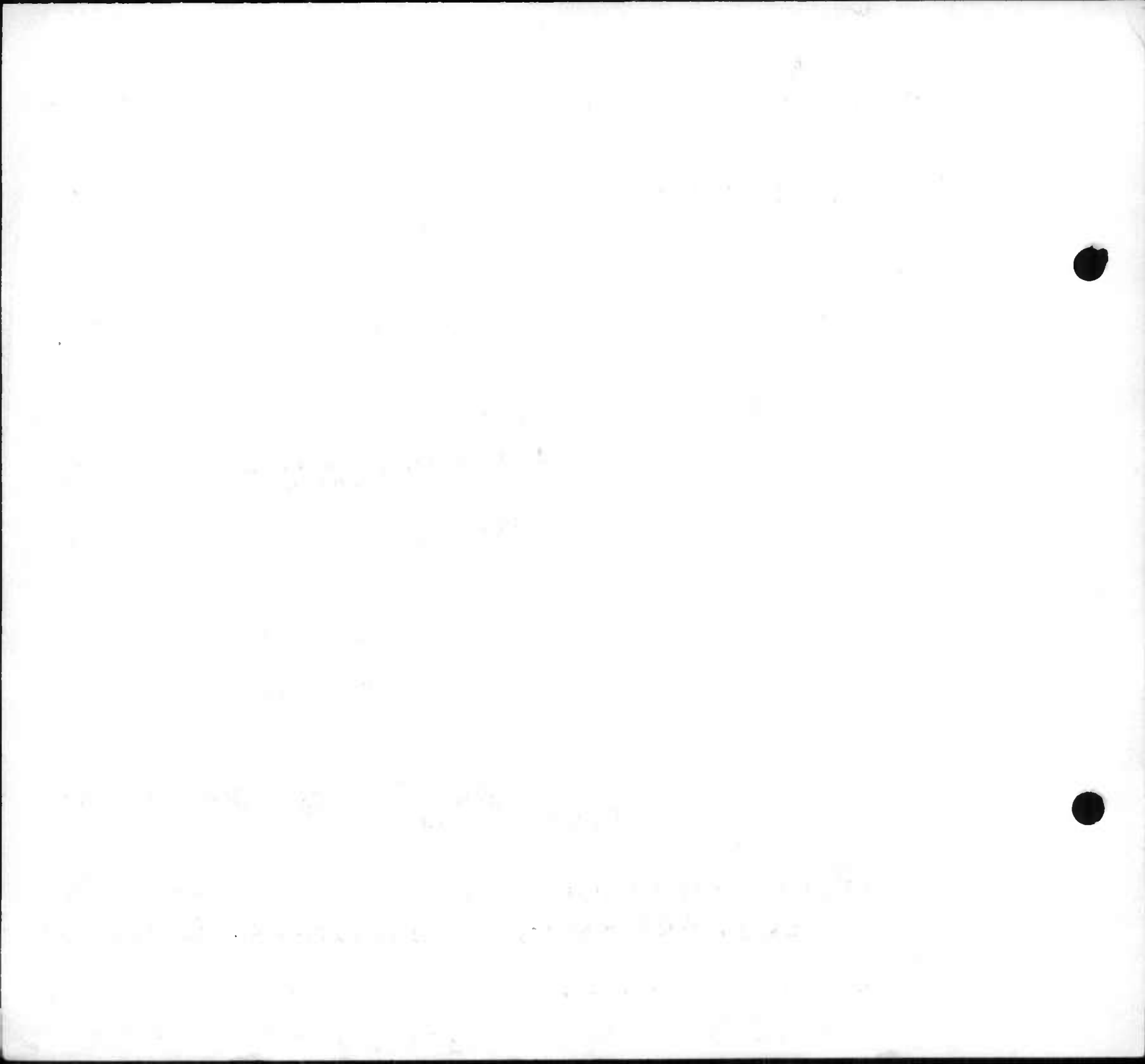
JAN 2 1970

Howe Jenkins & Sons Co. 4905 York Rd. Balto, Md. 21212



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				69 13062		REG. NO. 69 13062	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>King, William H</u>				2. DATE AND HOUR OF DEATH <u>12-30-69</u> <u>9:00 A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>Bon Secours Hospital</u> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION <u>Fayette St, Balto, MD.</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>1903</u>			
5. SEX <u>MALE</u> 6. RACE <u>White</u>				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-6-94</u> 9. AGE (In years last birthday) <u>75</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10B. KING OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>George King</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Good</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <u>Yes</u> If yes, give war or dates of service <u>W.W. #1</u>				16. SOCIAL SECURITY NO. <u>218-12-4346</u>		17. INFORMANT <u>George King (Brother)</u> ADDRESS <u>539 S. Monroe St #21223</u>	
18. <u>41241</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Acute cerebrovascular accident</u>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>ASCVD</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:		<u>years</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Bronchopneumonia</u>				(C) _____		<u>days</u>	
19A. DATE OF OPERATION <u>21</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) <u>1 Month</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>Jan 15 1958</u> to <u>Dec 30 1969</u> that (I) (we) last saw the deceased alive on <u>Dec 30 1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Henry Armanas</u>				23B. DATE SIGNED <u>Dec 30 1969</u>			
23C. PHYSICIAN'S NAME (Type) <u>HENRY ARMANAS</u>				23D. ADDRESS <u>1934 Wilkens Ave. Balto 23, Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-3-70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Houdens Park</u>		24D. LOCATION (City, town, or county) <u>Balto, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 2 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Faber, MD.</u>		25C. FUNERAL DIRECTOR <u>SGHargrave</u>		ADDRESS <u>- Frederick Ave</u>	



1
A-416

BALTIMORE CITY HEALTH DEPARTMENT

69 13063

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 13063

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) PAULINE M. ALBERTS		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year December 26, 1969		Hour M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2105 Wilkens Avenue		3. DATE PRONOUNCED DEAD Month Day Year December 26, 1969		Hour M. 1:00 A.
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland		B. COUNTY 2005		
6. SEX Female	7. RACE White	8. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore
9. DATE OF BIRTH JAN. 15, 1907		10. AGE (In years last birthday) 63		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.		E. STREET AND NUMBER 2105 Wilkens Avenue
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO.		18. INFORMANT CHAS. A. ALBERTS
19. 412.2 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH Hypertensive cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) (Partial) Yes
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (m.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Isidore Mihalakis, M.D. M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED December 26, 1969				
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12-29-69		24C. NAME OF CEMETERY or CREMATORY NEW CATHEDRAL
24D. LOCATION (City, town, or county) (State) BALTO. MD.		25A. DATE REC'D BY HEALTH DEPT. JAN 2 1970		
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR George L. Schwalb		ADDRESS 2101 FRED'K AVE BALTO. MD. 21223

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69 13064

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 13064

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) BEATRICE S. BACKUS		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 12 26 69 Hour 10:45a M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2017 W. Baltimore St.		3. DATE PRONOUNCED DEAD Month Day Year Hour Dec. 26, 1969 10:45a M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2003			
6. SEX Female	7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH 4-20-1914	10. AGE (In years lost birthday) 55	E. STREET AND NUMBER 2017 W. Baltimore St.	
11. BIRTHPLACE (State or foreign country) Norfolk, VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hairdresser		15. MOTHER'S MAIDEN NAME Lillie P.	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 218-10-7665	
18. INFORMANT Mrs Fox		ADDRESS Alexander VA.	
19. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12/27/69			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 1-2-70	24C. NAME of CEMETERY or CREMATORY Louder Park	24D. LOCATION (City, town, or county) (State) Balto. Md.
25A. DATE REC'D BY HEALTH DEPT. JAN 2 1970	25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	25C. FUNERAL DIRECTOR ADDRESS George L. Schwab, Balto, Md.	

ACADEMIC JOURNAL

ARTICLE

VOLUME 10

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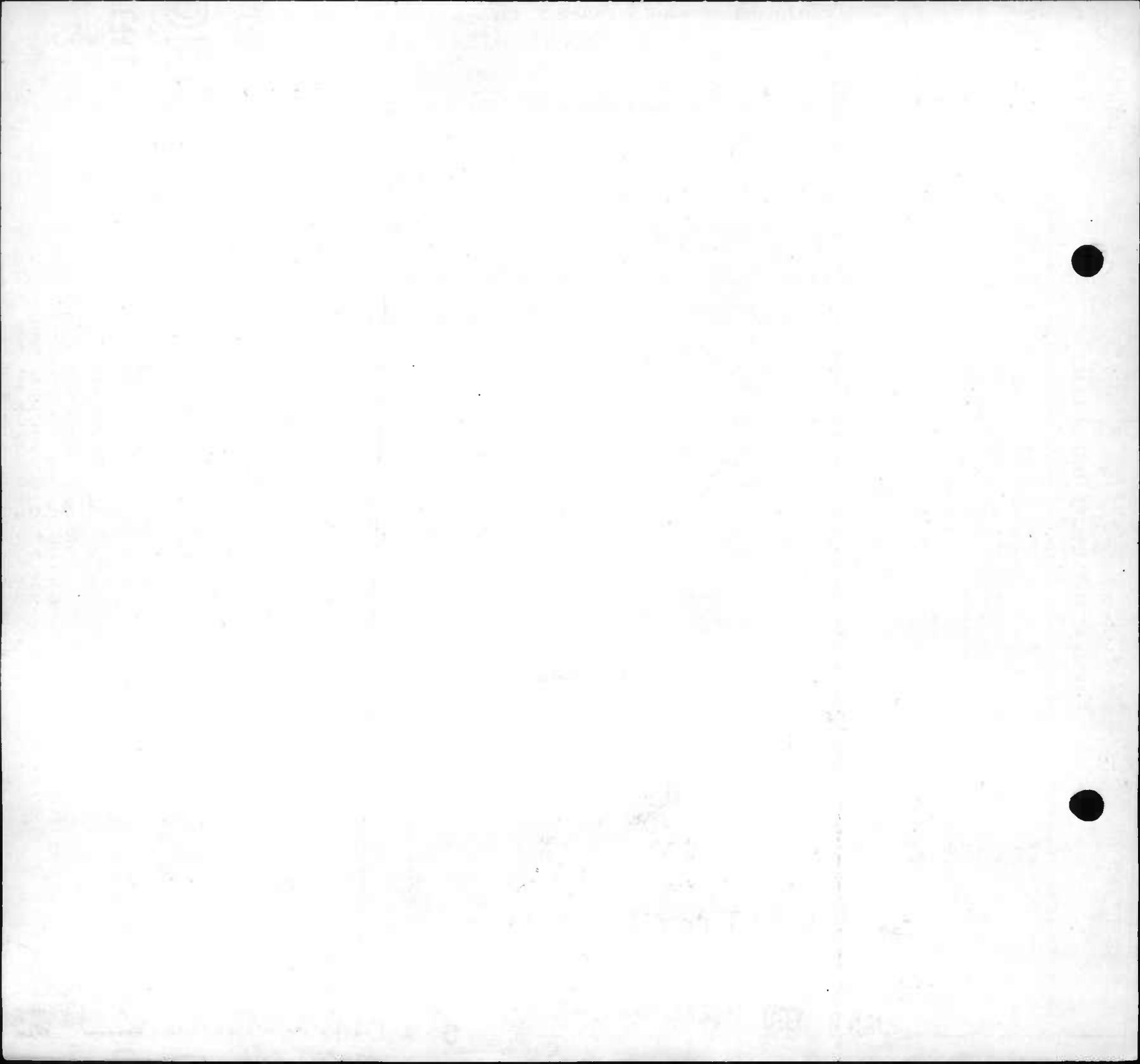
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 69 13065				BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO. 69 13065	
1. NAME OF DECEASED (Type or Print) SIMMS, Pauline				2. DATE AND HOUR OF DEATH Dec. 22, 1969 10:05 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD The Johns Hopkins Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY HOWARD 6300			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) The Johns Hopkins Hospital				C. CITY OR TOWN CLARKSVILLE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
				E. STREET AND NUMBER MEADOWVIEW CIRCLE			
5. SEX Female	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/3/20	9. AGE (In years last birthday) 49	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10B. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) Arkansas	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME John A. Blackwell				14. MOTHER'S MAIDEN NAME Tina Jane Cole			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO.		17. INFORMANT James Simms - Clarksville Md	
18. 124X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Pulmonary Embolism ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Cor Pulmonale Carcinoma of Breast				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cor Pulmonale Carcinoma of Breast (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 minutes 12 years 13 years							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 2/19/56				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Ca of Breast		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE David J. Pierson MD				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12/22/69	
23C. PHYSICIAN'S NAME (Type) David J. Pierson MD				23D. ADDRESS Johns Hopkins Hospital, Baltimore			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 12/26/69		24C. NAME OF CEMETERY OR CREMATORY Union Cemetery	
24D. LOCATION (City, town, or county) (State) Burtonsville Md							
25A. DATE REC'D BY HEALTH DEPT. JAN 2 1970				25B. NAME OF REGISTRAR Robert E. Jaber, M.D.		25C. FUNERAL DIRECTOR James Simms	
ADDRESS James Simms							



J-145 1

69 13066

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

69 13066

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

STEVEN JABLONSKI

2. DATE AND HOUR OF DEATH

DEC. 26, 1969

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

31

BALTIMORE City Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE 8. COUNTY

MARYLAND

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

810 S. KENWOOD AVENUE

5. SEX

MALE

6. RACE

WHITE

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

JUNE 3 1926

9. AGE (In years
last birthday)

43 yrs

If Under 1 Yr.

Months: Days:

If Under 24 Hrs.

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

BOILER MAKER

10B. KIND OF BUSINESS OR INDUSTRY

RENNEBURG

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

MICHAEL JABLONSKI

14. MOTHER'S MAIDEN NAME

MARYANN MALENKO

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18. 410.91

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Coronary Thrombosis

(B)

DUE TO, OR AS A CONSEQUENCE OF:

Atherosclerotic heart disease

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

Sudden

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (Notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME

(Month) (Day) (Year) (Hour)

(APPROX.)

21E. INJURY OCCURRED

While At ☐Not While ☐

Work

At Work

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 10/20 1964 to present 19
that (I) (we) last saw the deceased alive on 10/27/69 19 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) ~~did not~~ view the body after death.

23A. SIGNATURE

Dr. B. Kaplan

DEGREE

Attending
Phys. ☒Med.
Director ☐Staff
Phys. ☐

23B. DATE SIGNED

12/29/69

23C. PHYSICIAN'S
NAME (Type)

Irvin B. Kaplan

DEGREE

23D. ADDRESS

124 S Broadway Balt Md 21231

24A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

24B. DATE

DEC. 30 1969

24C. NAME OF CEMETERY OR CREMATORY

ST. Stanislaus Cem.

24D. LOCATION

BALTIMORE

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

JAN 2 1970

25B. NAME OF REGISTRAR

Robert E. Taylor, MD

25C. FUNERAL DIRECTOR

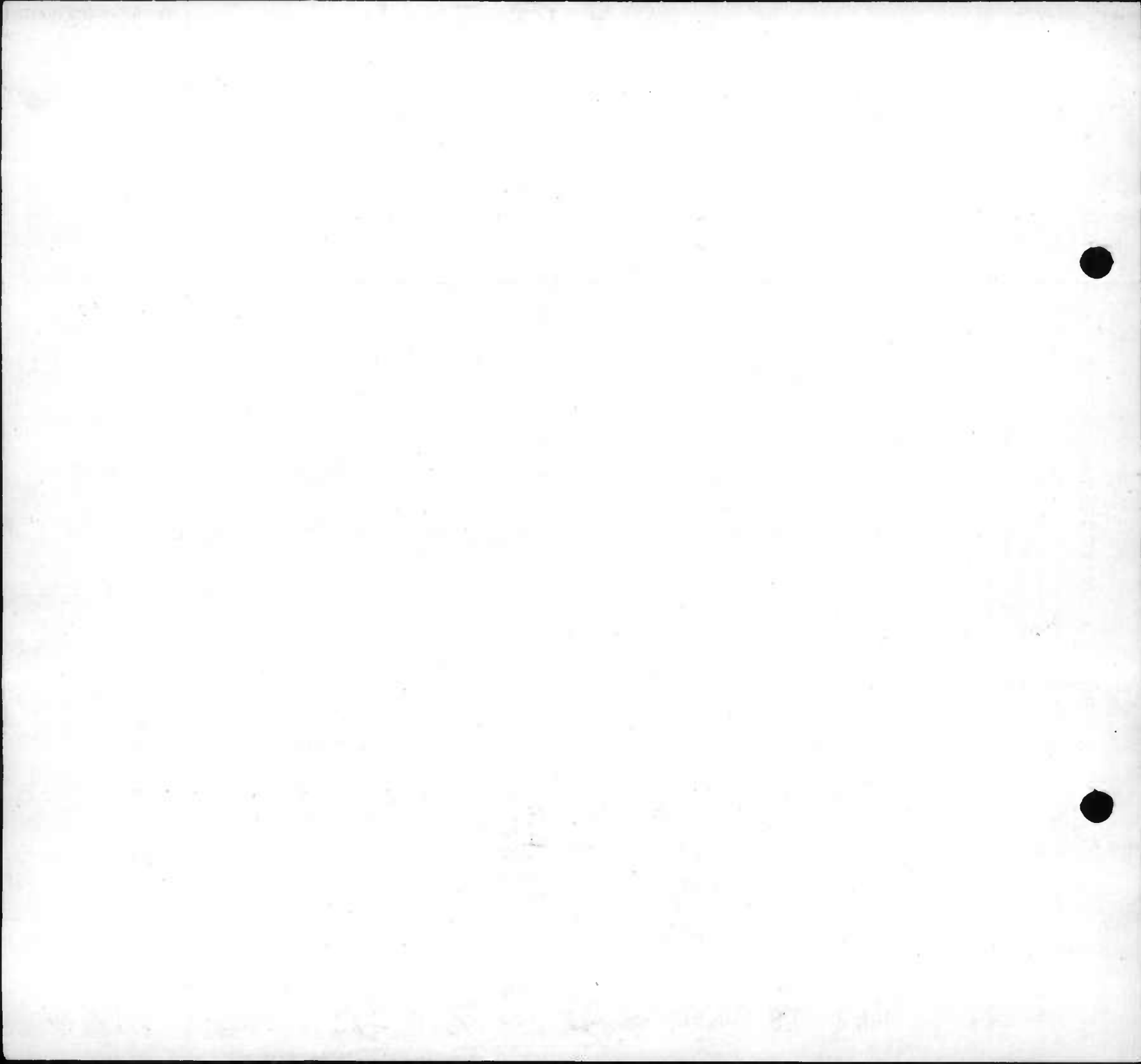
Raymond K. Kaczorowski

ADDRESS

2525 FLEET ST.

FUNERAL DIRECTOR: IMPORTANT

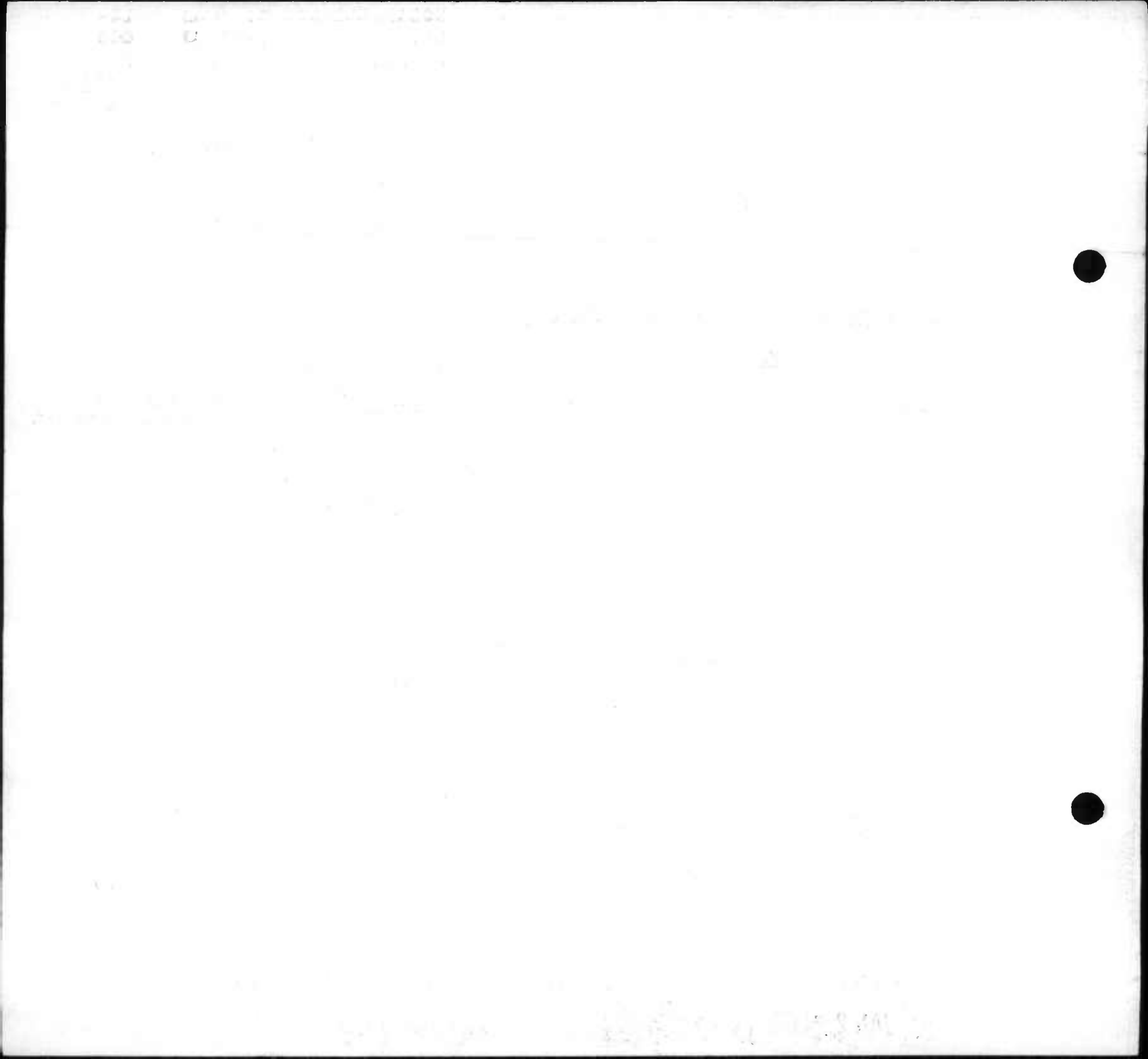
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

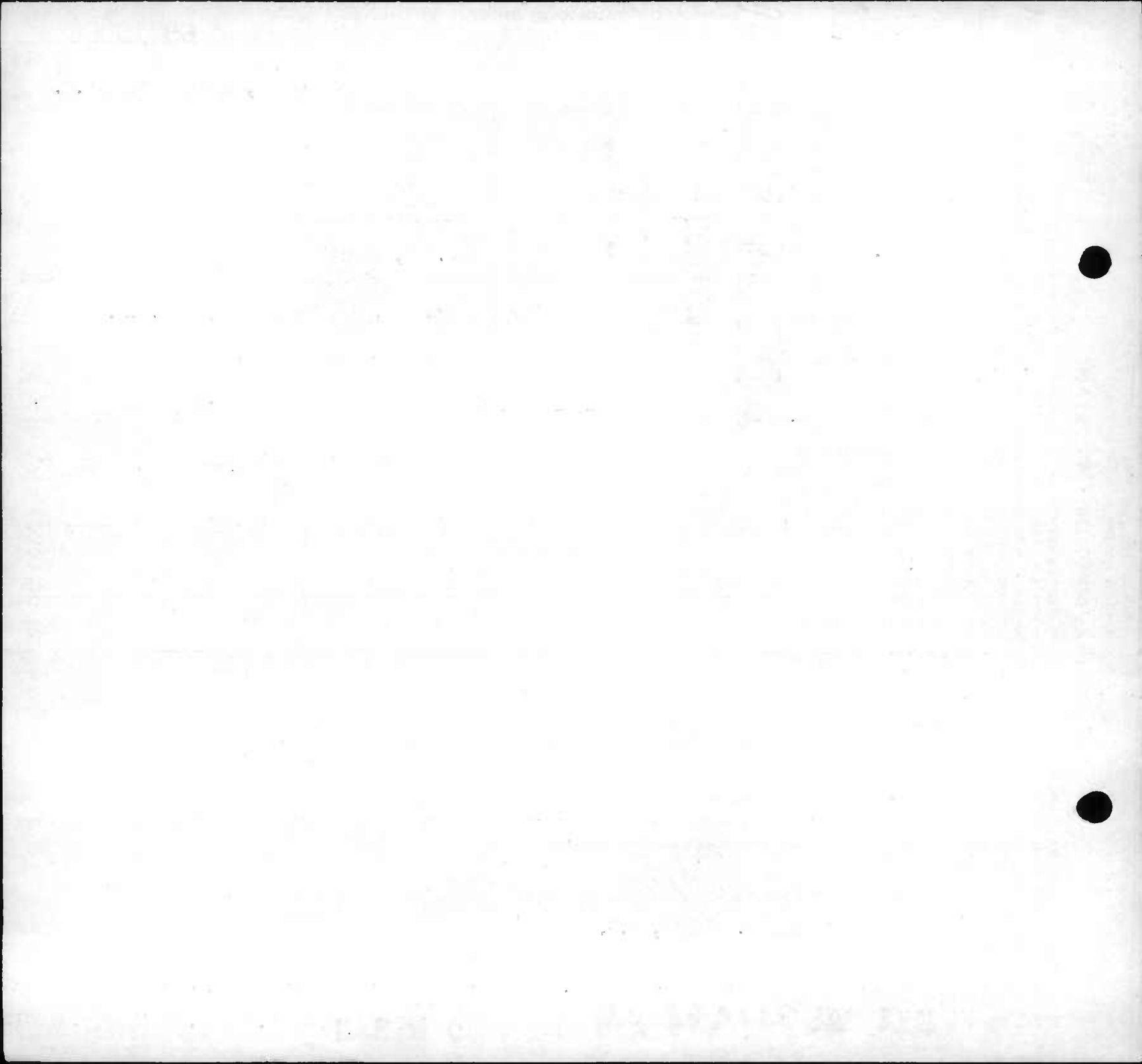
BIRTH NO. 69 13067		BALTIMORE CITY HEALTH DEPARTMENT NOLAN, ELEANOR G. DR. CAMPBELL, JR. DA. JAA		REG. NO. 27-89 69 13067	
1. NAME OF DECEASED (Type or Print) Eleanor G. Nolan		2. DATE AND HOUR OF DEATH Dec. 31 1969 1:50 AM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Univ. Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY Prince Georges		C. CITY OR TOWN Lanham 20801 D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX F 6. RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/20/09 9. AGE (In years last birthday) 60		10. UNDER 1 Yr. Months: Days: 11. UNDER 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SECRETARY		10B. KIND OF BUSINESS OR INDUSTRY Insurance Business		11. BIRTHPLACE (State or foreign country) Md. 12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Frederick O. Gaither		14. MOTHER'S MAIDEN NAME Hortense McKee		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO	
16. SOCIAL SECURITY NO.		17. INFORMANT MRS. Hortense Scott (Sister) 4620 Timber Ln, Lanham, Md.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 188X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Transitionial cell Ca of urinary bladder		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: urinary bladder (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 mos.			
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Mechanical GI obstruction 1 week					
21A. DATE OF OPERATION 12/12/69		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED GI obstruction		21C. AUTOPSY? (Yes or No) NO	
21D. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21E. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21F. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21G. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21H. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21I. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Nov 30 1969 to Dec 31 1969 and that (I) (we) last saw the deceased alive on Dec 31 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE David S McHold		23B. PHYSICIAN'S NAME (Type) DAVID S McHold		23C. ADDRESS UNIV HOSP	
23D. DATE SIGNED Dec 31, 1969		23E. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) CREMATION		24B. DATE Dec 31, 1969		24C. NAME OF CEMETERY OR CREMATORY FORT LINCOLN Crematory	
24D. LOCATION Bladensburg, Md.		24E. DATE REC'D BY HEALTH DEPT. JAN 2 1970			
24F. NAME OF REGISTRAR Robert E. Faber, MD.		24G. FUNERAL DIRECTOR Lanham Funeral Home, Lanham, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

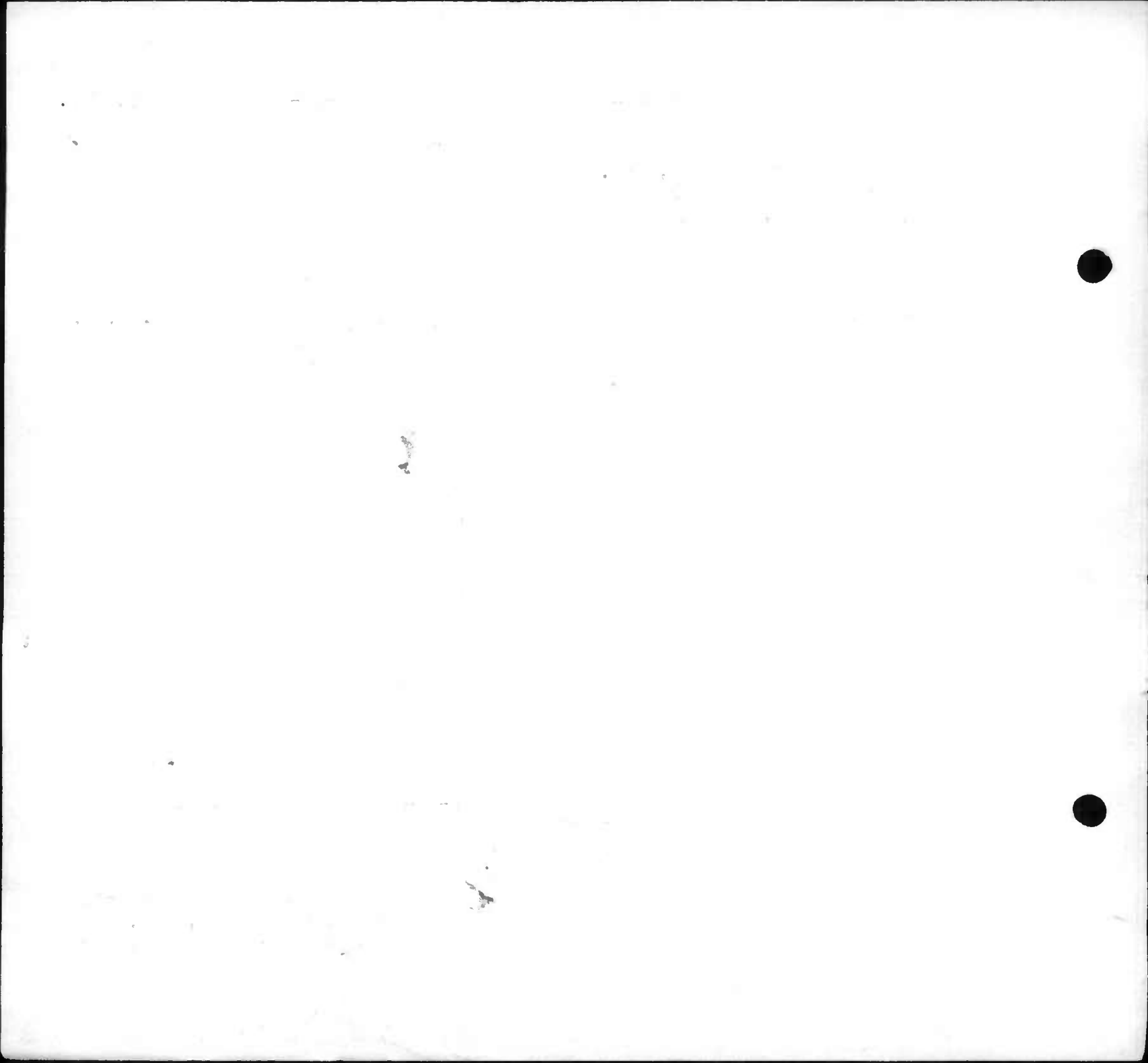
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 13068
S-432 69 13068		CERTIFICATE OF DEATH		
BIRTH NO. 1. NAME OF DECEASED (Type or Print) Sister Margaret Shields		2. DATE AND HOUR OF DEATH December 31, 1969 8:50 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 94 Villa Saint Michael		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY City C. CITY OR TOWN City of Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4000 Forest Hill Road 21207		
5. SEX F.	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 24, 1892	9. AGE (In years lost birthday) 77 years If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper		10B. KIND OF BUSINESS OR INDUSTRY Sister of Charity		
11. BIRTHPLACE (State or foreign country) Syracuse, New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Daniel Shields		14. MOTHER'S MAIDEN NAME Mary McMahon		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 263-98-0498-J1		17. INFORMANT Sister Andrea ADDRESS Same address
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cardiovascular collapse (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carcinoma of the brain (B) DUE TO, OR AS A CONSEQUENCE OF: (C)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 5 years
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from October, 1967 to December, 1969 , that (I) (we) last saw the deceased alive on December 30, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Damian P. Alagia				23B. DATE SIGNED 12/31/69
23C. PHYSICIAN'S NAME (Type) Damian P. Alagia, M.D.		23D. ADDRESS		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/3/69		24C. NAME of CEMETERY or CREMATORY Villa St. Michael on grounds Seton Institute
24D. LOCATION (City, town, or county) (State) 6400 Wabash Avenue 21215		25A. DATE REC'D BY HEALTH DEPT. JAN 5 1970		
25B. NAME OF REGISTRAR Robert E. [Signature]		25C. FUNERAL DIRECTOR STEWART & MOTT ADDRESS CO.108 W.North Ave.21201		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-250 69 13069		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 69 13069	
BIRTH NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) Katherine Jackson			12-30-69 7:35 p. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Provident Hospital, Inc. 1514 Division Street Baltimore, Maryland 21217			A. STATE Maryland 8. COUNTY 1501		
C. CITY OR TOWN Baltimore			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER 1374 Fremont Avenue					
5. SEX F	6. RACE N N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT 1, 1900	9. AGE (In years last birthday) 69	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME FRANK BAIL		14. MOTHER'S MAIDEN NAME ELINA BAIL		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS WILBERT MATTHEWS 1374 W. FREMONT	
18. 269.91 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE Severe Malnutrition and Dehydration DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12-30-69 19 to 12-30-69 19 that (I) (we) last saw the deceased alive on 12-30-69 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Raymundo R. Corpuz, M.D.			23B. DATE SIGNED 12-31-69		
23C. PHYSICIAN'S NAME (Type) Raymundo R. Corpuz, M.D.			23D. ADDRESS Provident Hospital, Inc. 1514 Division Street - Baltimore, Maryland		
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE 1/3/70		24C. NAME OF CEMETERY OR CREMATORY MT ARBURN CEMETERY	
24D. LOCATION (City, town, or county) (State) WEST FLORET BALTO MD					
25A. DATE REC'D BY HEALTH DEPT. JAN 5 1970		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS DONALD E. G. LOVER 170 W. PATTERSON	



69 13070

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 13070

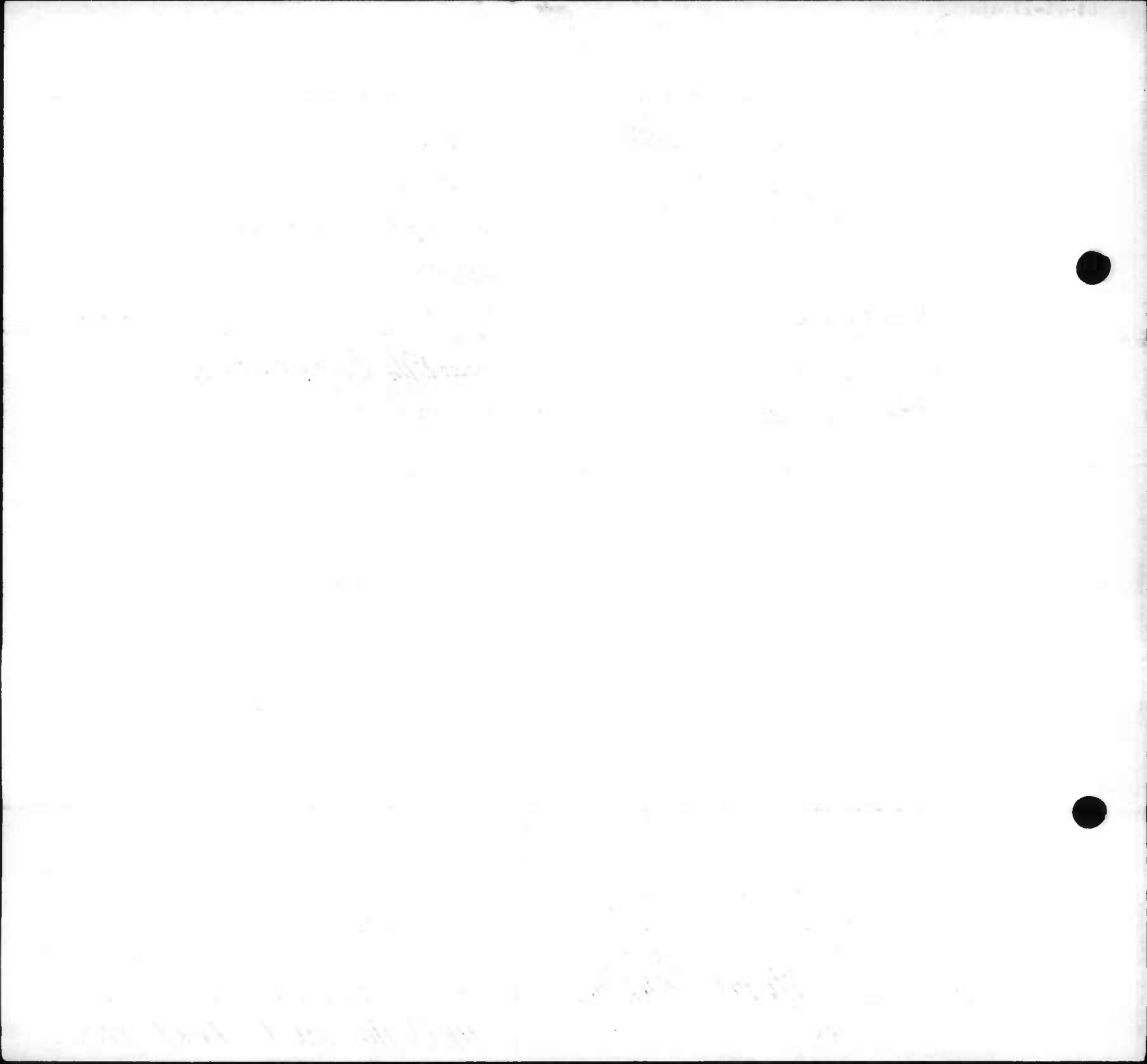
BIRTH NO.

1. NAME OF DECEASED (Type or Print) RALPH MILLION				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month 12 Day 30 Year 1969 Estimated <input type="checkbox"/>			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 48 MARYLAND GENERAL HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				3. DATE PRONOUNCED DEAD Month December Day 30 Year 1969 Hour 11:20 A.			
6. SEX Male				7. RACE White		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 9-23-1910				10. AGE (In years last birthday) 59		11. BIRTHPLACE (State or foreign country) West Virginia	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Wayne Million		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Carroll 5600	
15. MOTHER'S MAIDEN NAME Annie Harman				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No			
17. SOCIAL SECURITY NO. 218-12-8669				18. INFORMANT Mrs. Ralph Million			
19. 4410 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Dissecting aortic aneurysm ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Arteriosclerotic Cardiovascular Disease OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION 2				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
21. AUTOPSY? (Yes or No) yes							
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?							
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22F. HOW DID INJURY OCCUR?							
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 12/31/69 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 1-2-1970			
24C. NAME OF CEMETERY or CREMATORY Bixler's Cemetery				24D. LOCATION (City, town, or county) (State) Westminster Md.			
25A. DATE REC'D BY HEALTH DEPT. JAN 5 1970				25B. NAME OF REGISTRAR Robert E. Taylor, Jr.			
25C. FUNERAL DIRECTOR Tipton-Eling Fun. Home				ADDRESS Hampstead, Md.			

ACADEMIC

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

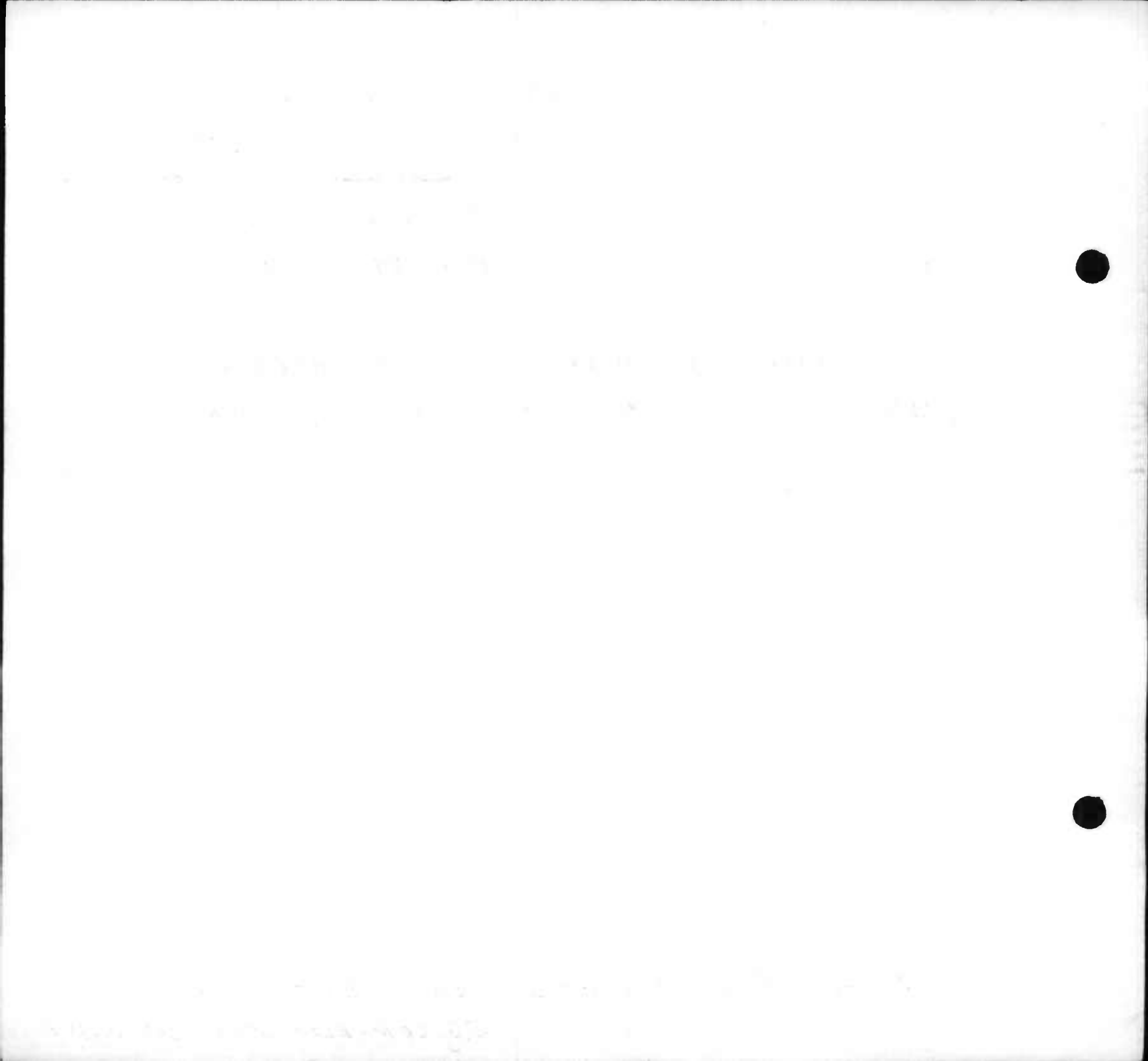
D-520		69 13071		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 13071	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>JOSEPH DENNIS</u>				2. DATE AND HOUR OF DEATH <u>DECEMBER 31, 1969</u> <u>8:15 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>BALTIMORE CITY HOSPITALS</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland 21224</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1202</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3006 Guilford Avenue 21218</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>6-28-18</u>	9. AGE (In years last birthday) <u>51</u>	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Arthur DENNIS</u>			14. MOTHER'S MAIDEN NAME <u>ELLA CARPENTER</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>yes</u> <u>WWII</u>			16. SOCIAL SECURITY NO. <u>220-07-3419</u>		17. INFORMANT <u>4940 Eastern Avenue</u> ADDRESS <u>BCH:Records Baltimore, Maryland 21224</u>		
18. <u>57391</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE <u>ACUTE RENAL FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>ANEMIA</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>LIVER FAILURE</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 DAYS</u> <u>5 DAYS</u> <u>3 WK</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <u>3 12/29/69</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>EXPLORATORY LAPAROTOMY - BILIOGASTRIC OBSTRUCTION</u>		20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>yes</u> <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (N) (this hospital) attended the deceased from <u>DECEMBER 13</u> 19 <u>69</u> to <u>DECEMBER 31</u> 19 <u>69</u> that (U) (we) last saw the deceased alive on <u>DECEMBER 31</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (U) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Michael M. McConnell, M.D.</u>				23B. DATE SIGNED <u>DECEMBER 31, 1969</u>		23C. PHYSICIAN'S NAME (Print) <u>Michael M. McConnell M.D.</u>	
23D. ADDRESS <u>BALTIMORE CITY HOSPITALS</u> <u>4940 Eastern Avenue Baltimore, Maryland 21224</u>							
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/6/70</u>		24C. NAME of CEMETERY or CREMATORY <u>Glen Haven Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Glen Burnie - Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 5 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR <u>130 E. Fort Ave.</u>			



FUNERAL DIRECTOR: IMPORTANT

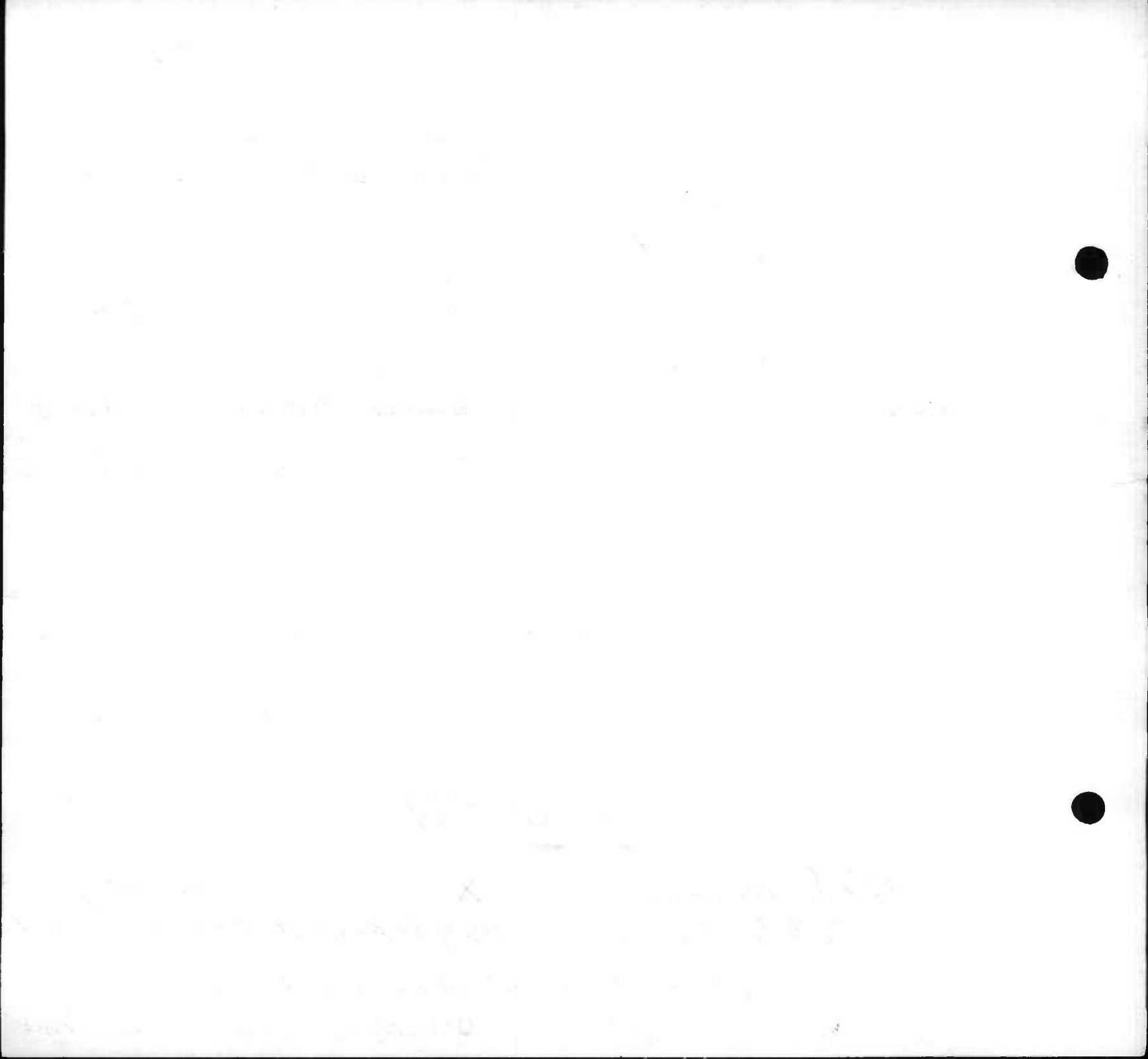
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-246		69 13072		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO.		69 13072	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH					
		ANNA E. DEUCHLER				12/31/69		6 A. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)						A. STATE B. COUNTY					
CHURCH HOME AND HOSPITAL 35						MD. BALTO 5300					
						C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
						E. STREET AND NUMBER 626 ROCKAWAY BEACH AVE.					
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (in years last birthday)		If Under 1 Yr. Months		If Under 24 Hrs. Days	
F	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10.16.89		80					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
HOUSEWIFE						N. C.			AMERICA		
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
GEORGE DEUCHLER						MC GARETTY					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS		
NONE				216 58 1875		HUSBAND			626 ROCKAWAY BEACH AVE		
18. CAUSE OF DEATH						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: LYMPHOSARCOMA (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			2 YEARS.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).						Generalized exfoliative dermatitis					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?							
		White At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>									
22. I certify that (I) (this hospital) attended the deceased from 12/18/69 to 12/31/69 that (I) (we) last saw the deceased alive on 12/31/69 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE						23B. DATE SIGNED					
A. E. CHOUVALIT, M.D.						12/31/69.					
23C. PHYSICIAN'S NAME (Type)						23D. ADDRESS					
A. E. CHOUVALIT, M.D.											
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county)		24E. (State)			
BURIAL		1/3/69		PARKWOOD CEM		BALTO. MD.					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS					
JAN 5 1970		Robert E. Taylor, M.D.		J. E. GONNELLY SONS		300 MAACE					



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

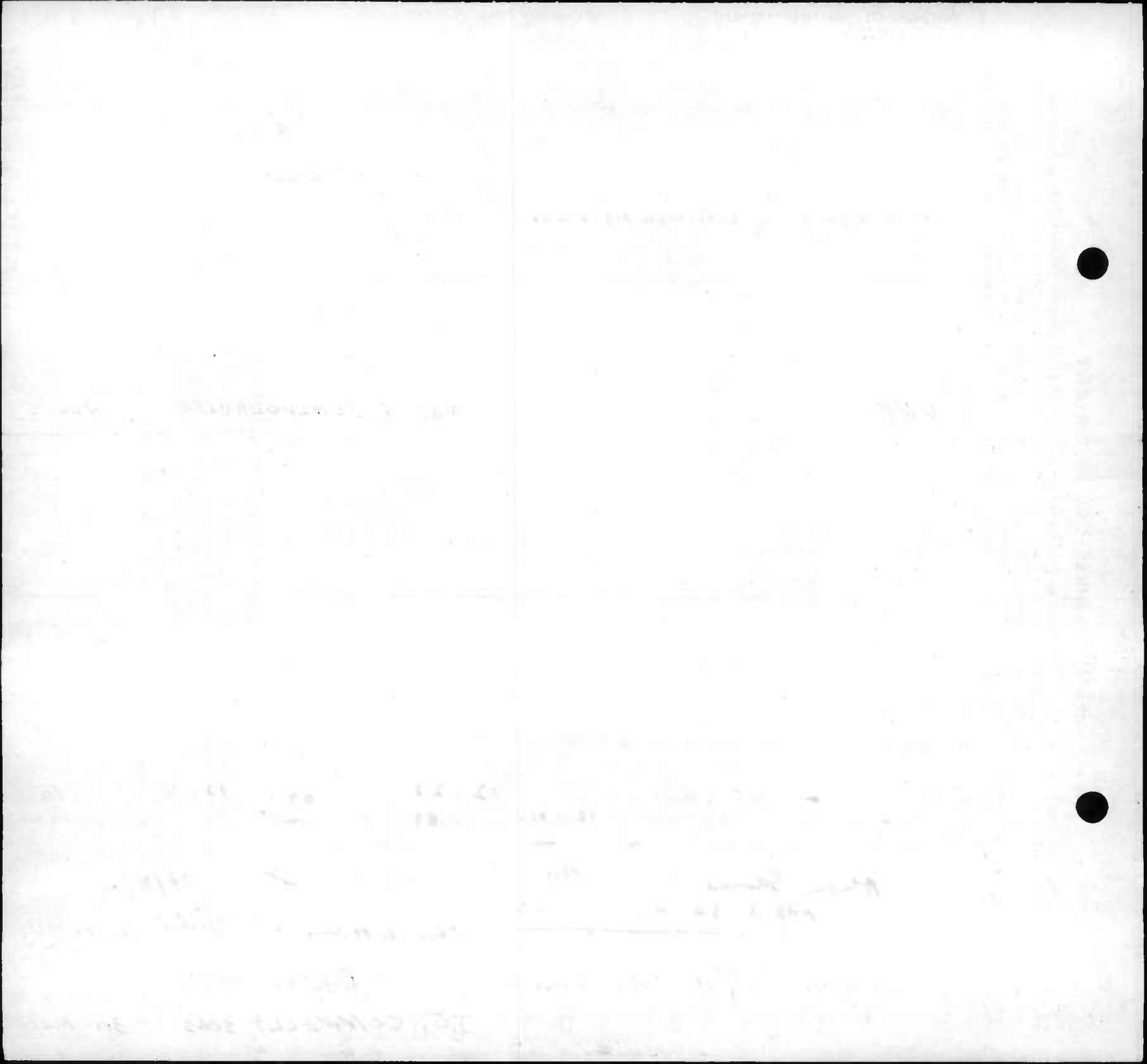
P-450		69 13073		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO.		69 13073	
CERTIFICATE OF DEATH											
1. NAME OF DECEASED (Type or Print) Mr. William E. Pulliam						2. DATE AND HOUR OF DEATH December 31, 1969 1954 ^{MM}					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Bon Secours Hospital						4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY BALTO 5300					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bon Secours Hospital						C. CITY OR TOWN Baltimore			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER 905 Catherine Avenue											
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/13/16	9. AGE (In years last birthday) 53 yrs	10. Under 1 Yr. Months Days		11. Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Jail Guard				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Walter Pulliam						14. MOTHER'S MAIDEN NAME Gordon					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNK				16. SOCIAL SECURITY NO. 216-14-3227		17. INFORMANT ELAINE PULLIAM			ADDRESS ABOVE		
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Myocardial infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 1 hour											
19. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Duodenal ulcer 2 years											
19A. DATE OF OPERATION 0				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notably medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 12-27-69 19 to 12-31-1969 that (I) (we) last saw the deceased alive on 12-31-1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
23A. SIGNATURE S. G. Sullivan						Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED 12-31-69		
23C. PHYSICIAN'S NAME (Type) S. G. Sullivan						23D. ADDRESS 1129 St Paul St Baltimore Md.					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1/3/70		24C. NAME of CEMETERY or CREMATORY GARDENS OF FAITH				24D. LOCATION (City, town, or county) (State) BALTO. MD.			
25A. DATE REC'D BY HEALTH DEPT. JAN 5 1970				25B. NAME OF REGISTRAR REG. 306				25C. FUNERAL DIRECTOR Orndorff Funeral Home			
								ADDRESS 300 MACE			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

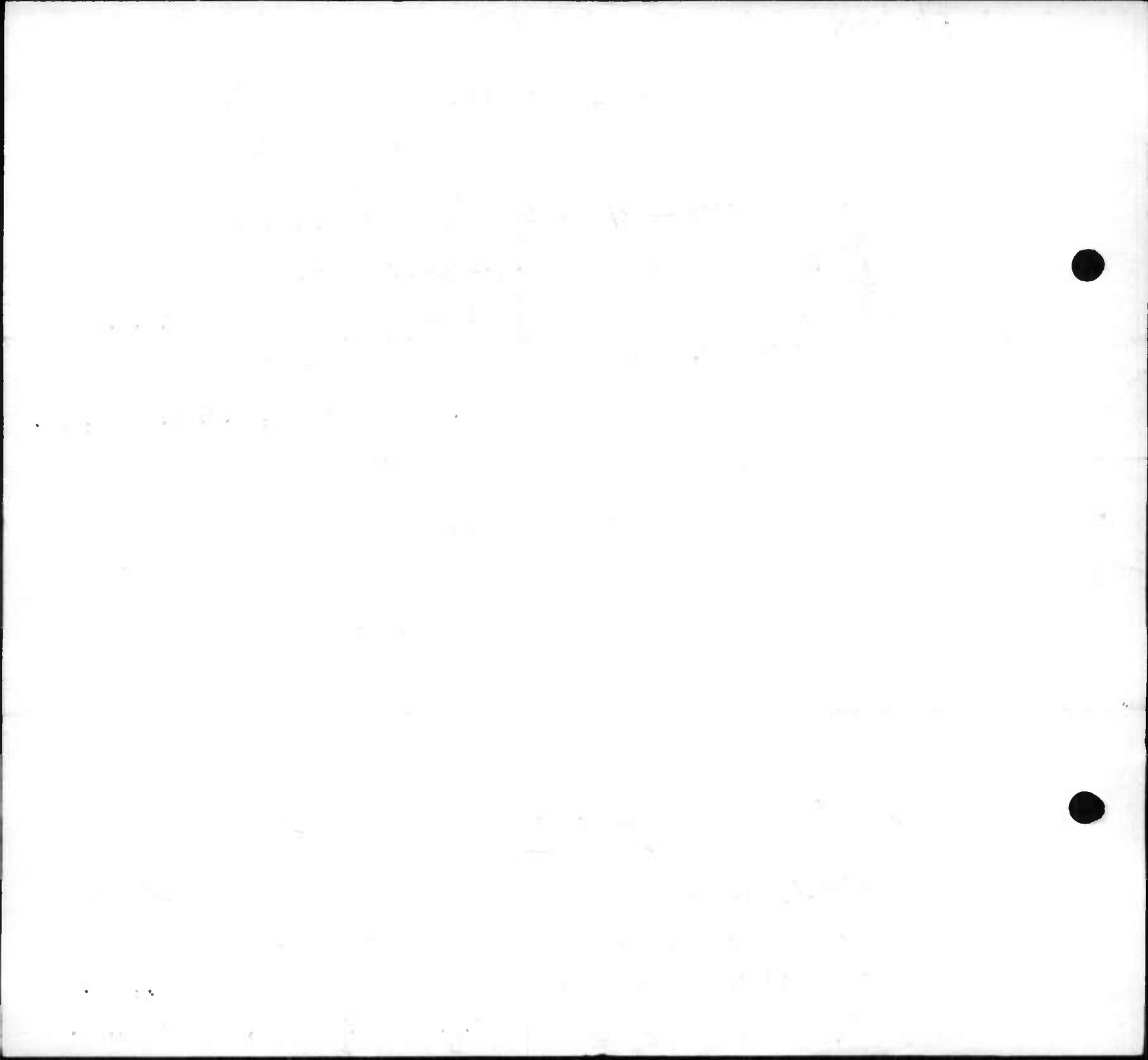
R-240		69 13074		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 69 13074	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) MRS. LENA ROESEL				2. DATE AND HOUR OF DEATH 12-31-69 12 25 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MD. B. COUNTY BALTO.				5. CITY OR TOWN D. INSIDE CITY LIMITS? BALTO. ESSEX YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
FULL NAME OF HOSPITAL OR INSTITUTION 35 CHURCH HOME & HOSPITAL 100 N Broadway Baltimore MD. 21231.		E. STREET AND NUMBER 407 S. MARLYN AVE.							
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-17-86		9. AGE (In years last birthday) 83		10. Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME JULIUS WAIR		14. MOTHER'S MAIDEN NAME MARIE BAGER							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNK		16. SOCIAL SECURITY NO. 220-46-6632		17. INFORMANT MRS. F. SCHLUERBERG		ADDRESS ABOVE			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE CARDIO-RESPIRATORY DUE TO, OR AS A CONSEQUENCE OF: ARREST (B) CERE BRO - VASCULAR ACCIDENT DUE TO, OR AS A CONSEQUENCE OF: 7 DAYS (C)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (H) (this hospital) attended the deceased from 12-22 19 69 to 12-31 19 69, that (H) (we) last saw the deceased alive on 12-31 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Abdus Samad		23B. DATE SIGNED 12/31/69		23C. PHYSICIAN'S NAME (Type) ABDUS SAMAD		23D. ADDRESS Church Home & Hospital Balto MD.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1/3/70		24C. NAME OF CEMETERY OR CREMATORY OAK LAWN		24D. LOCATION (City, town, or county) BALTO. MD.			
25A. DATE REC'D BY HEALTH DEPT. JAN 5 1970		25B. NAME OF REGISTRAR J. O. O.		25C. FUNERAL DIRECTOR J. O. CONNELLY SONS		ADDRESS 300 MACE			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

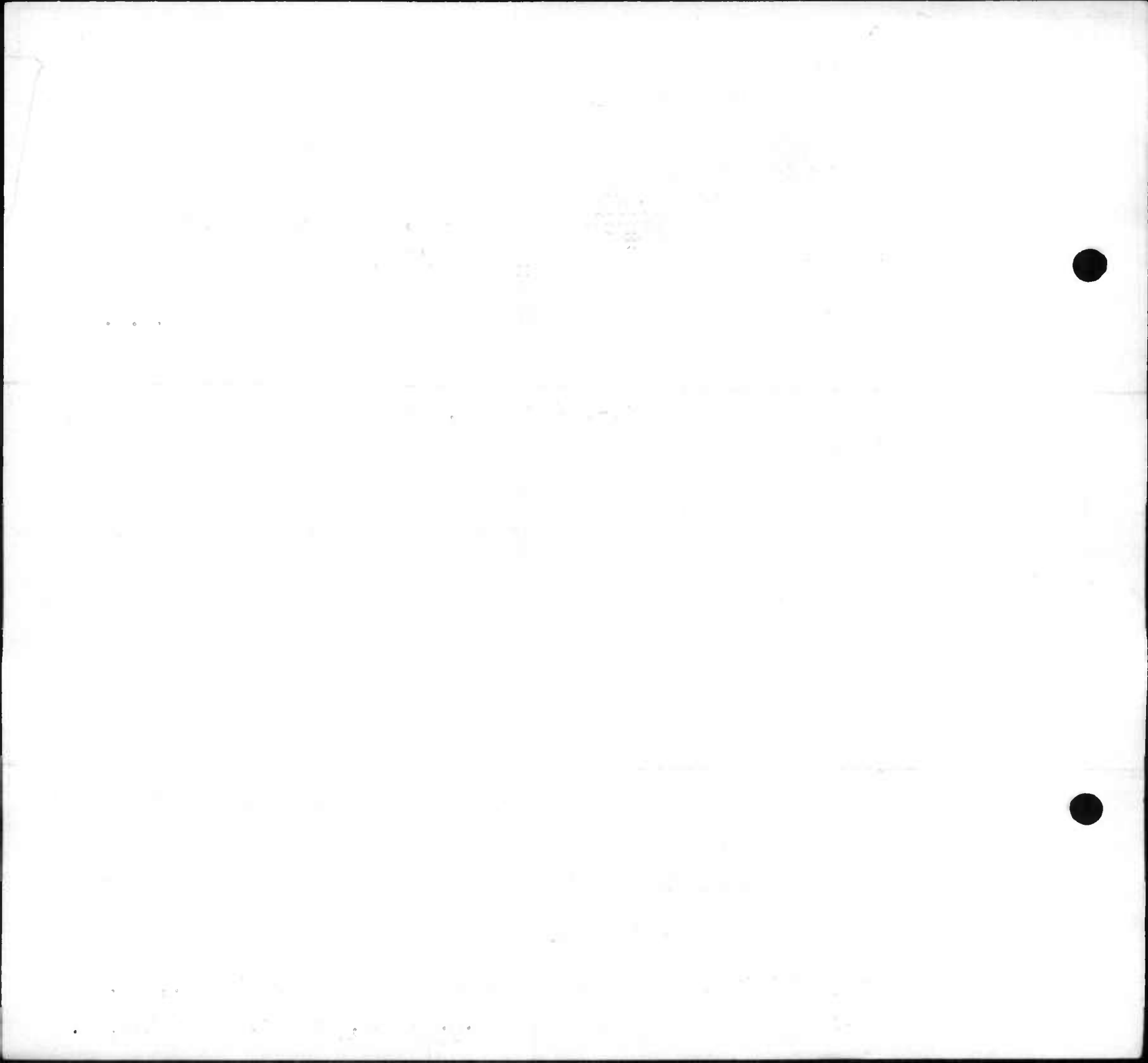
H-520		69 13075		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		X		REG. NO.		69 13075	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <u>HAINES, ROLAND E. HAINES</u>				2. DATE AND HOUR OF DEATH <u>12.30.69</u> ¹²⁴⁵			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Carroll</u>				M.			
FULL NAME OF HOSPITAL OR INSTITUTION <u>125 INNAI HOSPITAL MDALTO.</u>				(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <u>Sykesville, Md.</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
E. STREET AND NUMBER <u>Main St. Sykesville, Md.</u>											
5. SEX <u>M</u>		6. RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>12.21.29</u>		9. AGE (In years last birthday) <u>40</u>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William P. Haines</u>				14. MOTHER'S MAIDEN NAME <u>Naomi Esworthy</u>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>Yes</u>		17. INFORMANT <u>Mrs. Hazel Frizzell, Rt. 2, Mt. Airy, Md.</u>				ADDRESS	
18. <u>571.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>LIVER FAILURE</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>CIRRHOSIS</u>				CAUSE OF DEATH <u>LIVER FAILURE</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>CIRRHOSIS</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 wks.</u> <u>Years.</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>RENAL FAILURE</u>											
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that the (this hospital) attended the deceased from <u>12.22.69</u> 19__ to <u>12.30.69</u> 19__ that we (we) last saw the deceased alive on <u>12.30.69</u> 19__ and that in my (our) opinion death occurred on the date and hour and from the causes stated above. We (We) (did not) view the body after death.											
23A. SIGNATURE <u>M. Bodenheimer</u>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <u>12.30.69.</u>			
23C. PHYSICIAN'S NAME (Type) <u>M. Bodenheimer</u>				23D. ADDRESS <u>Smai Hospital</u>							
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/3/1970</u>		24C. NAME OF CEMETERY or CREMATORY <u>Prospect Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Frederick Co., Md.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 5 1970</u>		25B. NAME OF REGISTRAR <u>John E. Taylor</u>		25C. FUNERAL DIRECTOR ADDRESS <u>C.M. Waltz, Box 241, Sykesville, Md.</u>							



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

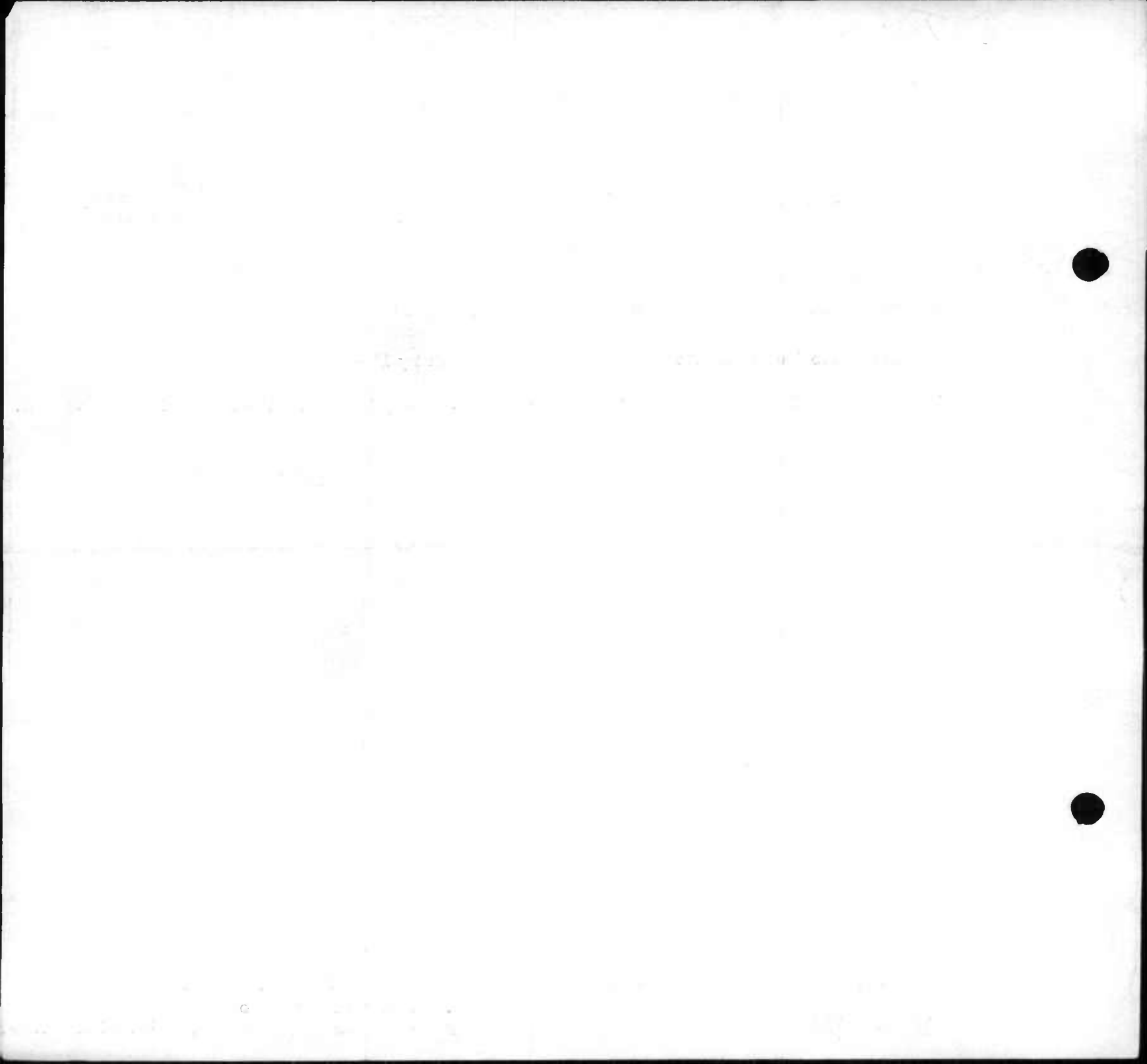
T-653		69 13076		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		X		REG. NO. 69 13076	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>THORNTON, LEONARD E.</u>				2. DATE AND HOUR OF DEATH <u>12-29-69</u> <u>11:35A.</u> M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>HOWARD</u>			C. CITY OR TOWN <u>MARYLAND</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>40 Saint Agnes Hospital</u> <u>Caton & Wilkens Aves.</u> <u>21229</u>						D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			E. STREET AND NUMBER <u>Rt 40, Marriottsville Md. Howard Co 21104</u>		
5. SEX <u>Male</u>		6. RACE <u>Neg</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>3/16/1907</u>		9. AGE (in years last birthday) <u>62</u>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>			12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13. FATHER'S NAME <u>Unknown</u>						14. MOTHER'S MAIDEN NAME <u>Unknown</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>218-18-4110</u>		17. INFORMANT <u>Mrs. Agnes Rheubottom</u>			ADDRESS <u>Same As #4</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>RESPIRATORY INSUFFICIENCY</u> (B) <u>CHRONIC PNEUMONIA</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>? 2-3 years</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).											
19A. DATE OF OPERATION <u>0</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>Dec, 29</u> 19 <u>69</u> to <u>Dec, 29</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>Dec, 29</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <u>Julio Freijanes MD.</u>						Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <u>12/29/69.</u>		
23C. PHYSICIAN'S NAME (Type) <u>Julio Freijanes MD.</u>						23D. ADDRESS					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>				24B. DATE <u>1/2/1970</u>		24C. NAME OF CEMETERY or CREMATORY <u>Fairview Cemetery</u>			24D. LOCATION (City, town, or county) (State) <u>Carroll Co., Md.</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 5 1970</u>				25B. NAME OF REGISTRAR <u>Walter E. Jackson</u>				25C. FUNERAL DIRECTOR <u>C. M. Maltz</u>			
ADDRESS <u>Box 241, Sykesville, Md.</u>											



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

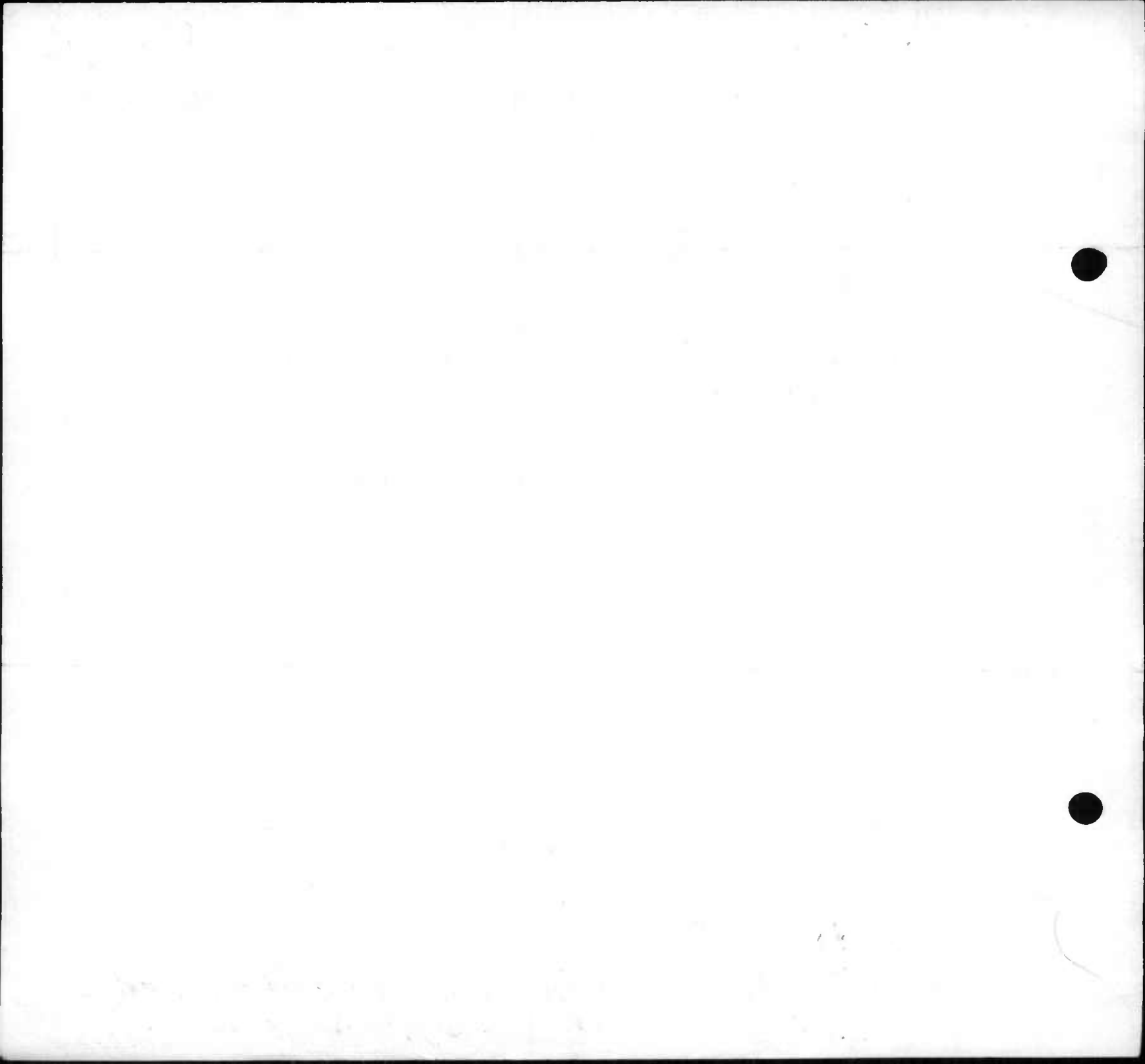
<div style="display: flex; justify-content: space-between;"> 7-554 69 13077 BALTIMORE CITY HEALTH DEPARTMENT </div> <div style="display: flex; justify-content: space-between;"> CERTIFICATE OF DEATH X </div>		REG. NO. 69 13077	
BIRTH NO. TUMMINELLO ANTHONY		2. DATE AND HOUR OF DEATH 12-30-69 2:15 A.M.	
1. NAME OF DECEASED (Type or Print) TUMMINELLO ANTHONY		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTO. CO.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD SINAI HOSPITAL OF BALTO.		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SINAI HOSPITAL OF BALTO.		E. STREET AND NUMBER 607 MAIN ST. REISTERSTOWN, MD.	
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-21-93
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Produce Driver		10B. KIND OF BUSINESS OR INDUSTRY Food	9. AGE (in years last birthday) 76
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Carmello Tumminello		14. MOTHER'S MAIDEN NAME Mary Porpura	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WW II		16. SOCIAL SECURITY NO. 218 32 3990	
17. INFORMANT Mrs. Mary Tumminello		21136 ADDRESS 607 Reisterstown Rd.	
18. 250.91 CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ACUTE RENAL INSUFF DAYS (B) CHRONIC RENAL INSUFF YEARS DUE TO, OR AS A CONSEQUENCE OF: (C) DIABETES MELLITUS YEARS	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). A. S. C. V. D. + C. V. A.		YEARS YEARS	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12-20 19 69 to 12-30 19 69 that (I) (we) last saw the deceased alive on 12-30 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE [Signature] M.D.		23B. DATE SIGNED 12-30-69	
23C. PHYSICIAN'S NAME (Type) CARLOS S. VALLEJO M.D.		23D. ADDRESS SINAI HOSP. OF BALTO.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2 JAN 70	
24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 5 1970		25B. NAME OF REGISTRAR [Signature]	
25C. FUNERAL DIRECTOR Lemmon		ADDRESS 4611 Park Heights Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

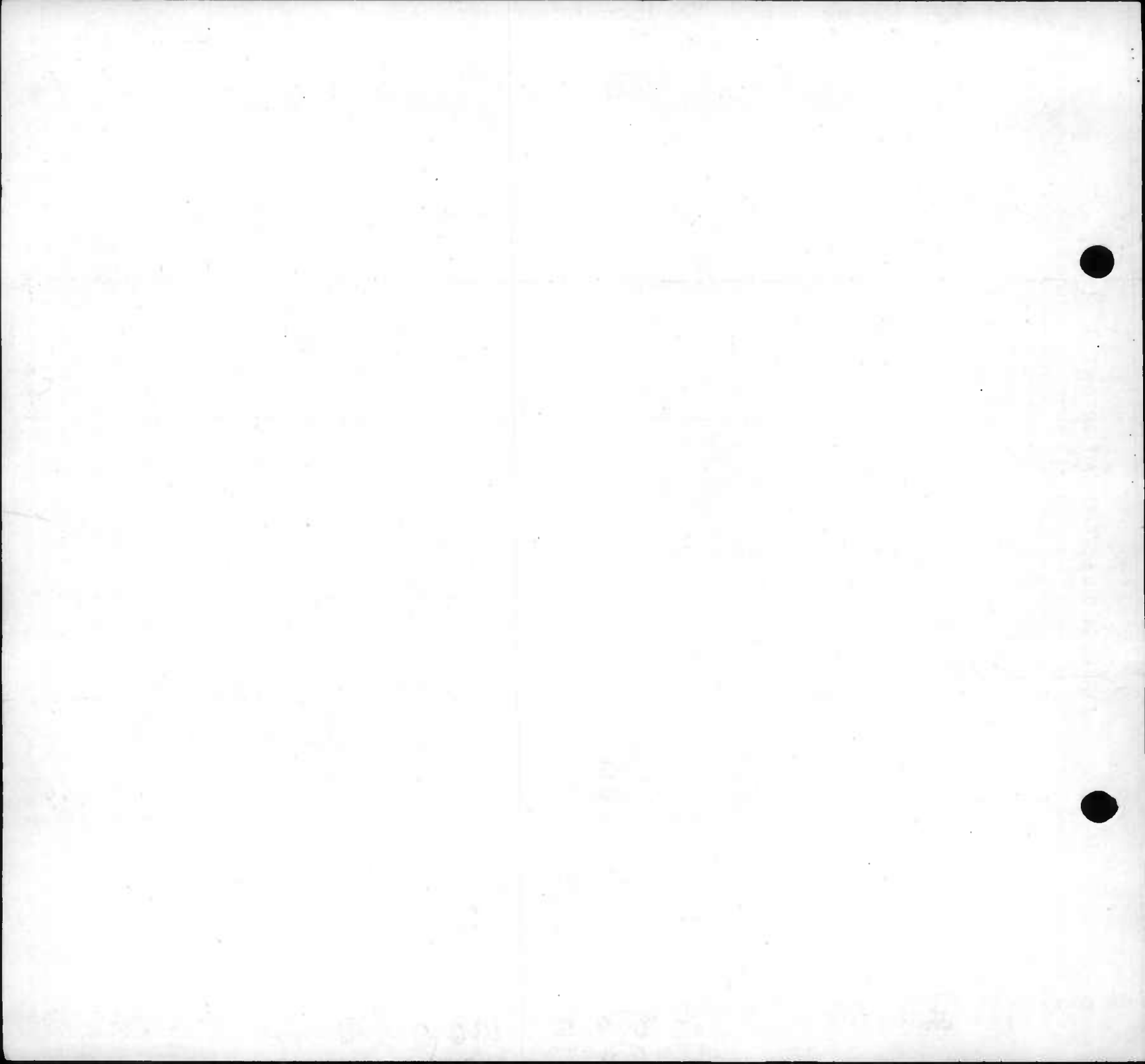
<h2 style="margin: 0;">B-650 69 13078</h2>		<h2 style="margin: 0;">BALTIMORE CITY HEALTH DEPARTMENT</h2>		<h2 style="margin: 0;">CERTIFICATE OF DEATH</h2>		<h2 style="margin: 0;">REG. NO. 69 13078</h2>	
BIRTH NO. <u>69-21922</u>		1. NAME OF DECEASED (Type or Print) <u>Bobby Francis Brown</u>				2. DATE AND HOUR OF DEATH <u>31-Dec-69 1 6 14 P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>South Baltimore General Hosp.</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2102</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1239 W. Cross St.</u>			
5. SEX <u>Male</u>	6. RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-Dec-69</u>	9. AGE (In years last birthday) <u>1</u>	10. Under 1 Yr. Months <u>1</u> Days <u>-</u>	11. Under 24 Hrs. Hours <u>-</u> Min. <u>-</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Neonate</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Bobby F. Brown</u>				14. MOTHER'S MAIDEN NAME <u>Mary K. Baker</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Parents</u>		ADDRESS <u>above</u>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE <u>Sepsis</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Born & Ruptured Omphalocele</u> 31 days DUE TO, OR AS A CONSEQUENCE OF: (C) <u>-</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION <u>2</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>-</u> 20A. AUTOPSY? (Yes or No) <u>Yes</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>No</u>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>-</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>-</u>		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>-</u>	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>-</u>		22. I certify that (N) (this hospital) attended the deceased from <u>1-Dec-69</u> to <u>31-Dec-69</u> that (I) (we) last saw the deceased alive on <u>31-Dec-69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Richard E. Fisher MD</u>				23B. DATE SIGNED <u>31-Dec-69</u>		23C. PHYSICIAN'S NAME (Type) <u>Richard E. Fisher MD</u>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/3/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Greenwood Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>St. Johns</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 5 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher</u>		25C. FUNERAL DIRECTOR <u>John P. Gorman</u>		ADDRESS <u>St. Johns</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

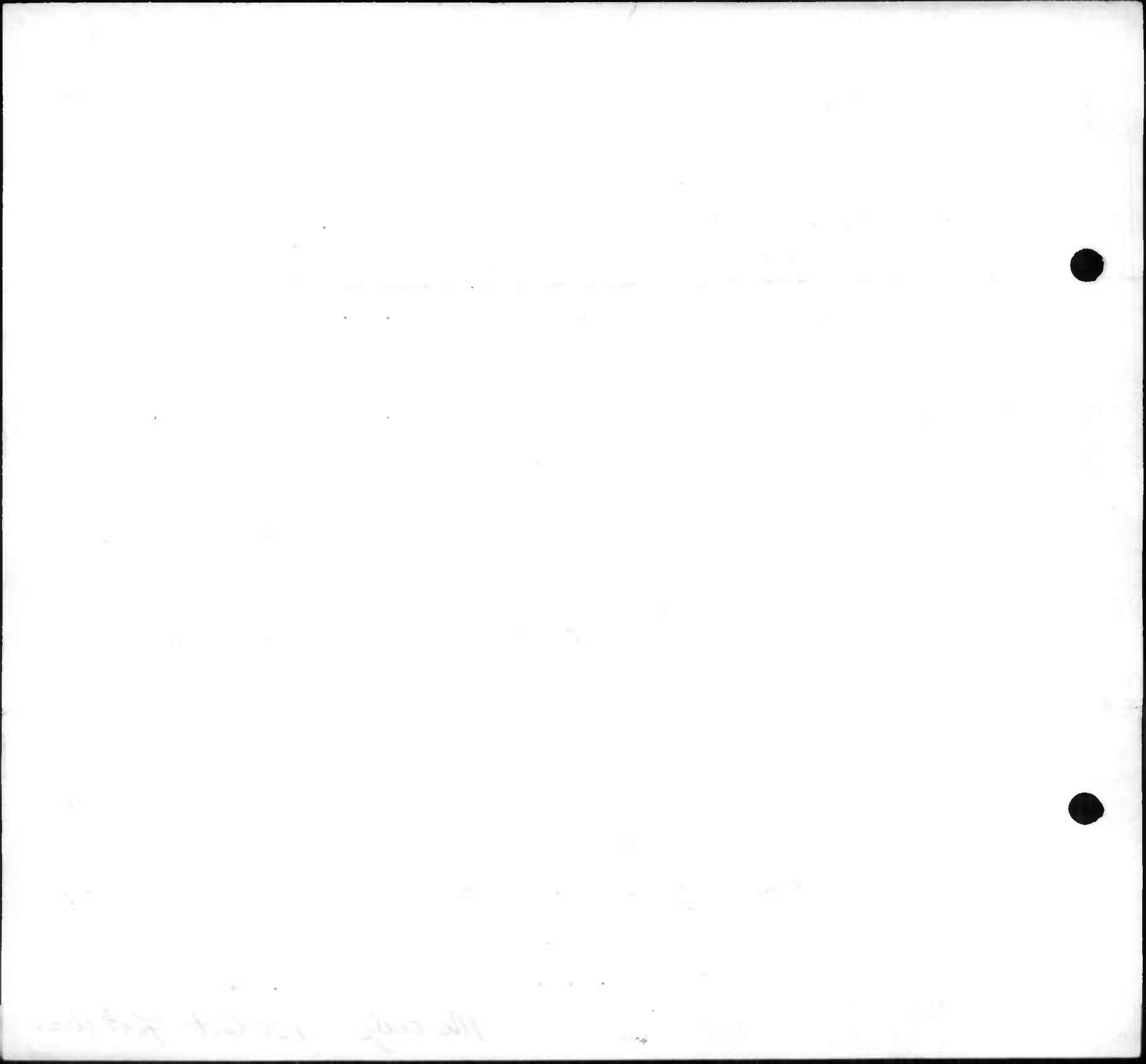
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 13079	
S-316 69 13079				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		STAFFORD, ANNA DAWSON		12-24-'69 10 ⁵⁸ P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Keswick				A. STATE MD.	
91700 W. 40th St.				C. CITY OR TOWN BALTO.	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 700 W. 40th ST.	
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-4-1878	9. AGE (In years last birthday) 91	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Verified		10B. KIND OF BUSINESS OR INDUSTRY U.S.F. + G		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Stafford			14. MOTHER'S MAIDEN NAME Mamie E. Dawson		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war and dates of service)		16. SOCIAL SECURITY NO. 219-16-6603		17. INFORMANT Vergie Crouch R.N.	
				ADDRESS Keswick	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 410.9 I		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Coronary Thrombosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, II		(B) DUE TO, OR AS A CONSEQUENCE OF: Cerebral embolism		2 yrs	
		(C).....			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Feb 19 65 to 24 Dec 19 69, that (I) (we) last saw the deceased alive on 24 Dec 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Harold P. Biehl MD				23B. DATE SIGNED 24 Dec 69	
23C. PHYSICIAN'S NAME (Type) Harold P. Biehl MD				23D. ADDRESS Keswick	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 12-30-69		24C. NAME OF CEMETERY or CREMATORY SPRINGHILL CEM.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 12-30-69		24C. NAME OF CEMETERY or CREMATORY SPRINGHILL CEM.	
24D. LOCATION (City, town, or county) (State) EASTON, MD.					
25A. DATE REC'D BY HEALTH DEPT. JAN 5 1970		25B. NAME OF REGISTRAR Vergie Crouch		25C. FUNERAL DIRECTOR Wm. D. Johnson & Sons Balto Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

5-160 69 13080		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 69 13080	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Joseph Edward Skirger</i>		2. DATE AND HOUR OF DEATH <i>12/31/69 1 30 P M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>2404</i>		C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>43 South Baltimore General Hospital</i>		E. STREET AND NUMBER <i>1702 Byrd St.</i>			
5. SEX <i>m</i>	6. RACE <i>w</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-3-96</i>	9. AGE (in years last birthday) <i>73</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Brakeman-retired</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Railroad</i>		11. BIRTHPLACE (State or foreign country) <i>Balto. Md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U S A</i>		13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes W W I</i>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>Gardner J. Stanke 1702 Byrd St.</i>	
18. <i>41231</i> CAUSE OF DEATH		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Acute Pulmonary Edema</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
		(B) <i>Arteriosclerotic Heart Disease</i> DUE TO, OR AS A CONSEQUENCE OF:			
		(C) _____			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>Pulmonary Emphysema</i>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>12-12</i> 19 <i>69</i> to <i>12-31</i> 19 <i>69</i> that (I) (we) last saw the deceased alive on <i>12-31</i> 19 <i>69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>DeLeonard M.D.</i>		23B. DATE SIGNED <i>12/31/69</i>			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1 5 69</i>		24C. NAME of CEMETERY or CREMATORY <i>Balto. U. S. National</i>	
24D. LOCATION (City, town, or county) (State) <i>Balto. Md.</i>		25A. DATE RECEIVED BY HEALTH DEPT. <i>JAN 5 1970</i>		25B. NAME OF REGISTRAR <i>0 0 1</i>	
25C. FUNERAL DIRECTOR <i>Mc Eully</i>		25D. ADDRESS <i>130 East Fort Ave.</i>			



BIRTH NO.		69 13081		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		REG. NO. 69 13081	
1. NAME OF DECEASED (Type or Print) FRANK SOKOLICH				2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/>		Month Day Year		Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 112 S. Washington Street				3. DATE PRONOUNCED DEAD December 30, 1969		Month Day Year		Hour M. 5:00 P.	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 604				6. SEX Male		7. RACE White		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
9. DATE OF BIRTH APRIL 1, 1919				10. AGE (In years last birthday) 50		11. BIRTHPLACE (State or foreign country) NEW JERSEY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FRANK SOKOLICH				14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DRIVER		15. MOTHER'S MAIDEN NAME NEDDIE ZIMNITZKY		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) YES WORLD WAR II	
17. SOCIAL SECURITY NO.				18. INFORMANT SONYA HELEN ZAPPARDINO		ADDRESS 3412 PARKLAWN AVE 21213		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(A) IMMEDIATE CAUSE Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF:		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION 2				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Minute)				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 12/31/69	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE JAN 2 1970		24C. NAME OF CEMETERY or CREMATORY HOLY TRINITY CEM.		24D. LOCATION (City, town, or county) (State) ELK RIDGE BALTO MD			
25A. DATE REC'D BY HEALTH DEPT. JAN 5 1970		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR THE RIPPEL BROS INC		ADDRESS 1800 E LOMBARD ST			

Letter from M.E.'s office 1-21-70 M.H.

John M. M. M.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-424		69 13082		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 13082	
BIRTH NO.				1			
1. NAME OF DECEASED (Type or Print) Carl Frank WALKLING				2. DATE AND HOUR OF DEATH Dec. 30, 1969 9:30 P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Pa. B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) US Public Health Service Hospital 2X3100 Wyman Parkway				C. CITY OR TOWN Philadelphia D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX M W 6. RACE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 9/5/05 9. AGE (In years last birthday) 64			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Captain				10B. KIND OF BUSINESS OR INDUSTRY Seafarer			
11. BIRTHPLACE (State or foreign country) Pa.				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Henry Walkling				14. MOTHER'S MAIDEN NAME Louise Hoephert			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 181-10-6498			
17. INFORMANT				ADDRESS Records- US PHS Hospital, Balto, Md.			
18. 1541 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH Metastatic adenocarcinoma of rectum			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 2				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20A. AUTOPSY? (Yes or No) yes				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from Nov. 10 19 69 to Dec. 30 19 69, that (I) (we) last saw the deceased alive on Dec. 30 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Gary E. Feldman, M.D.				23B. DATE SIGNED 12/31/69			
23C. PHYSICIAN'S NAME (Type) Gary E. Feldman, SA Surg (R)				23D. ADDRESS US PHS Hospital, Balto, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation 1/2/1970				24B. DATE 1/2/1970			
24C. NAME OF CEMETERY OR CREMATORY Green Mount Cemetery				24D. LOCATION (City, town, or county) - (State) Balto, Md.			
25A. DATE REC'D BY HEALTH DEPT. JAN 5 1970				25B. NAME OF REGISTRAR Robert J. Brooks			
25C. FUNERAL DIRECTOR				25D. ADDRESS 4200 Cooks Brooks, Towson, Md. 21204			



Wm. Cook & Sons, Inc.
New York, N. Y.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 13083

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

MILTON WEINER

2. DATE
OF
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

SINAI HOSPITAL (DOA)

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

December 30, 1969

10:11 P.M.

5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

Maryland

B. COUNTY

Baltimore

53-00

C. CITY OR TOWN

Randallstown

D. INSIDE CITY LIMITS?

YES ☐NO ☒

6. SEX

Male

7. RACE

White

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

9. DATE OF BIRTH

Feb 24, 1922

10. AGE (In years
last birthday)

47

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

3606 Belair Road Ave

11. BIRTHPLACE (State or foreign country)

Pa

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Harry

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Auto Dealer

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Paula

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

WW II

17. SOCIAL
SECURITY NO.

155-05-4074

18. INFORMANT

Wife

ADDRESS

Same

19.

8-12-0

CAUSE OF DEATH

Multiple Injuries

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, osteoporosis, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., In or about
home, farm, factory, street, office bldg., etc.)

Street

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Jones Falls Expressway-114 ft.S. of 5.7

22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.) 12-30-69 9:30 P. m.

22E. INJURY OCCURRED:

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Maker

Driver in auto-auto collision

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE

EXAMINER'S NAME (Type)

Ronald N. Kornblum, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/31/69

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

11/1/1970

24C. NAME of CEMETERY or CREMATORY

Mikro Kodesa

24D. LOCATION (City, town, or county)

Baltimore

(State)

Md

25A. DATE REC'D BY HEALTH DEPT.

JAN 5 1970

25B. NAME of REGISTRAR

Robert E. J. J.

25C. FUNERAL DIRECTOR

Schon & Son, Inc

ADDRESS

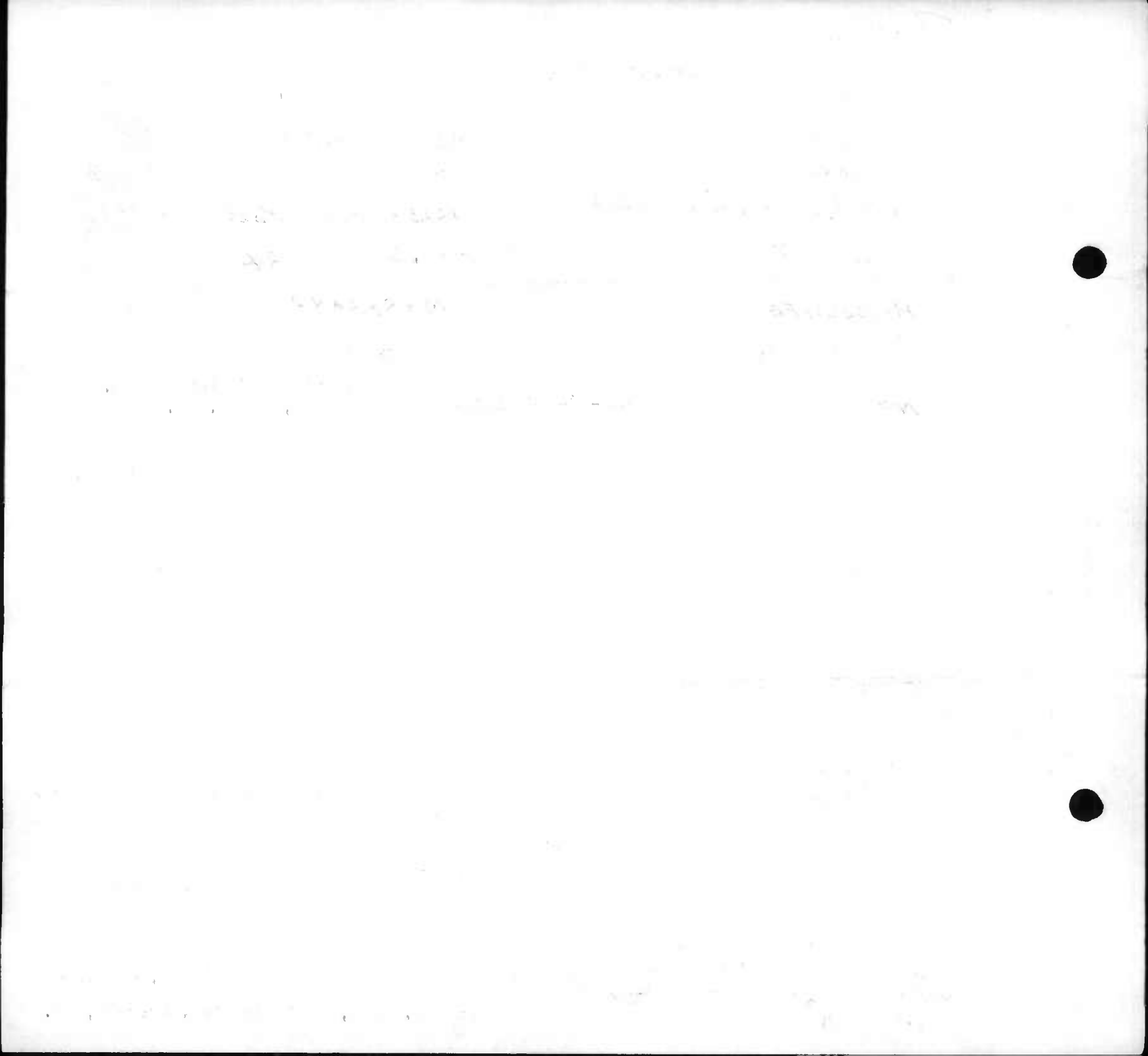
9610 Reisterstown Rd

100

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>69 13084</u>	
BIRTH NO. <u>8-252</u> <u>69 13084</u>		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>SCOGGINS Rose Anna</u>		2. DATE AND HOUR OF DEATH <u>DECEMBER 31, 1969</u> <u>5 30</u> P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>35 Church Home & Hospital</u> <u>Baltimore Maryland 21231</u> <u>Church Home & Hospital</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Sparrows Point</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>1225 Forrest Rd</u> <u>21219</u>	
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 8, 1885</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (in years last birthday) <u>84</u> If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Marik</u>		14. MOTHER'S MAIDEN NAME <u>Marie</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>212-58-1201</u>	
17. INFORMANT (Daughter) <u>Miss Allie Scoggins, Balto. Md. 21219</u>		ADDRESS	
18. <u>410.91</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>	
(A) IMMEDIATE CAUSE <u>Arteriosclerotic Cardiovascular Disease with cardiac arrest probably due myocardial infarction.</u>		(B) DUE TO, OR AS A CONSEQUENCE OF:	
(C) DUE TO, OR AS A CONSEQUENCE OF:			
II			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <u>12/28/69</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Cholecystitis & Cholelithiasis</u>	
20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>12/28</u> 19 <u>69</u> to <u>12/31</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>12/31</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>J. Martinez</u>		23B. DATE SIGNED <u>12/31/69</u>	
23C. PHYSICIAN'S NAME (Type) <u>J. MARTINEZ MD</u>		23D. ADDRESS <u>Medical Out Building - Baltimore Md 21201</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/5/70</u>	
24C. NAME OF CEMETERY or CREMATORY <u>Parkwood Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 5 1970</u>		25B. NAME OF REGISTRAR <u>Robert F. Taylor</u>	
25C. FUNERAL DIRECTOR <u>John J. Duda</u>		ADDRESS <u>7922 Wise Ave. Dundalk, Md.</u>	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) BENJAMIN JANICKI		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year December 31, 1969		Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1106 S. Conkling Street		3. DATE PRONOUNCED DEAD Month Day Year December 31, 1969		Hour 3:30 P. M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland		B. COUNTY 2609			
6. SEX Male	7. RACE White	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
9. DATE OF BIRTH July 19, 1894		10. AGE (In years last birthday) 75		11. Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF U. S. A.		13. FATHER'S NAME Paul Janicki	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Continental Can Co.		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Bernice ?	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 218-10-4979		18. INFORMANT (Wife) ADDRESS 1106 S. Conkling St. Balto. Md.	
19. 412.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) No	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (m.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Charles S. Springate, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> January 1, 1970					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/5/70		24C. NAME of CEMETERY or CREMATORY St. Stanislaus Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT. JAN 5 1970		25B. NAME OF REGISTRAR Robert E. Springate		25C. FUNERAL DIRECTOR ADDRESS John J. Duda, 2829 Hudson St. Balto. Md.	

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 10-10-2000 BY SP-6 BJS/STP

U.S. GOVERNMENT PRINTING OFFICE: 1980 O - 300-000

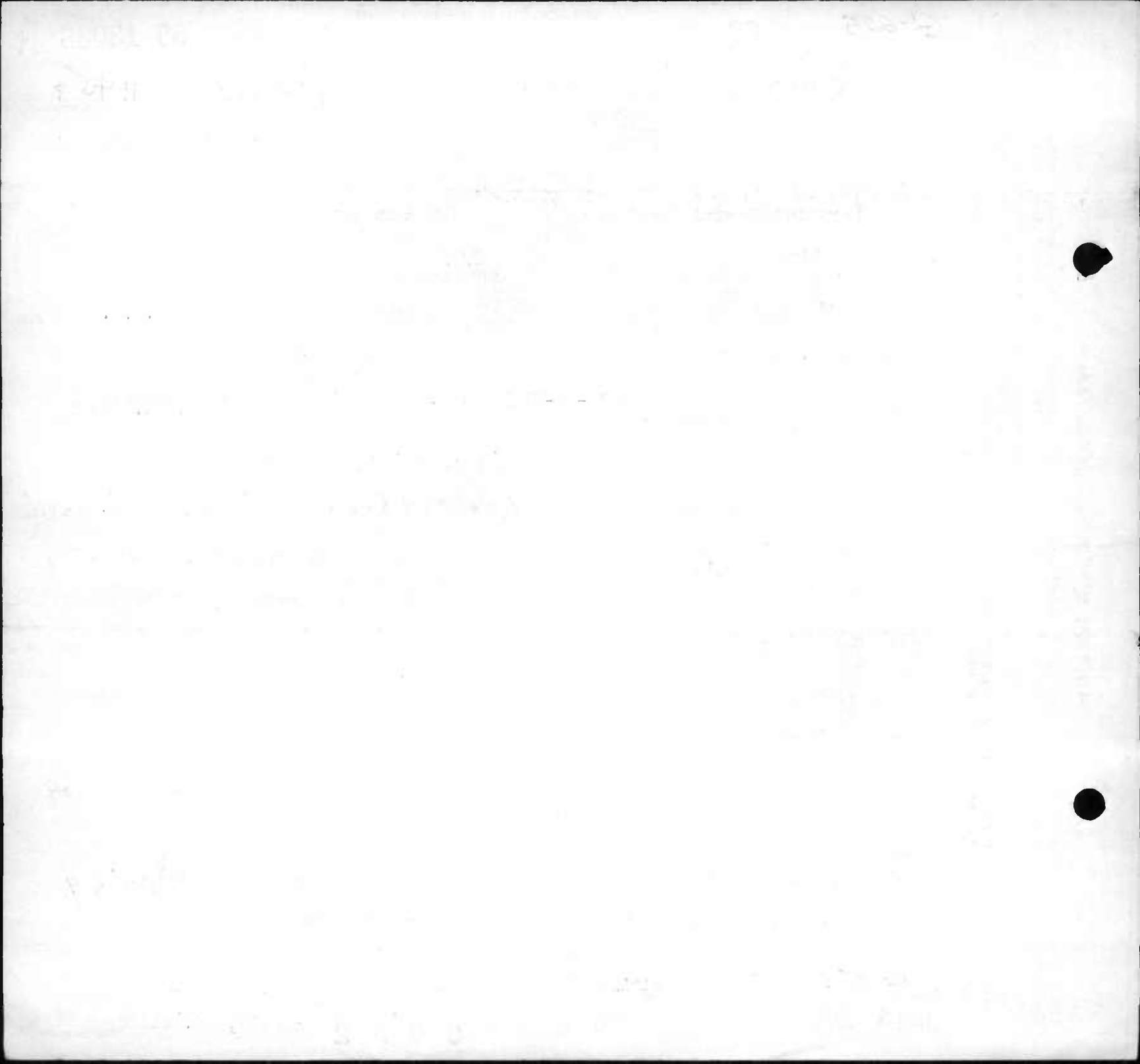
U.S. GOVERNMENT PRINTING OFFICE: 1980 O - 300-000

U.S. GOVERNMENT PRINTING OFFICE: 1980 O - 300-000

FUNERAL DIRECTOR: IMPORTANT

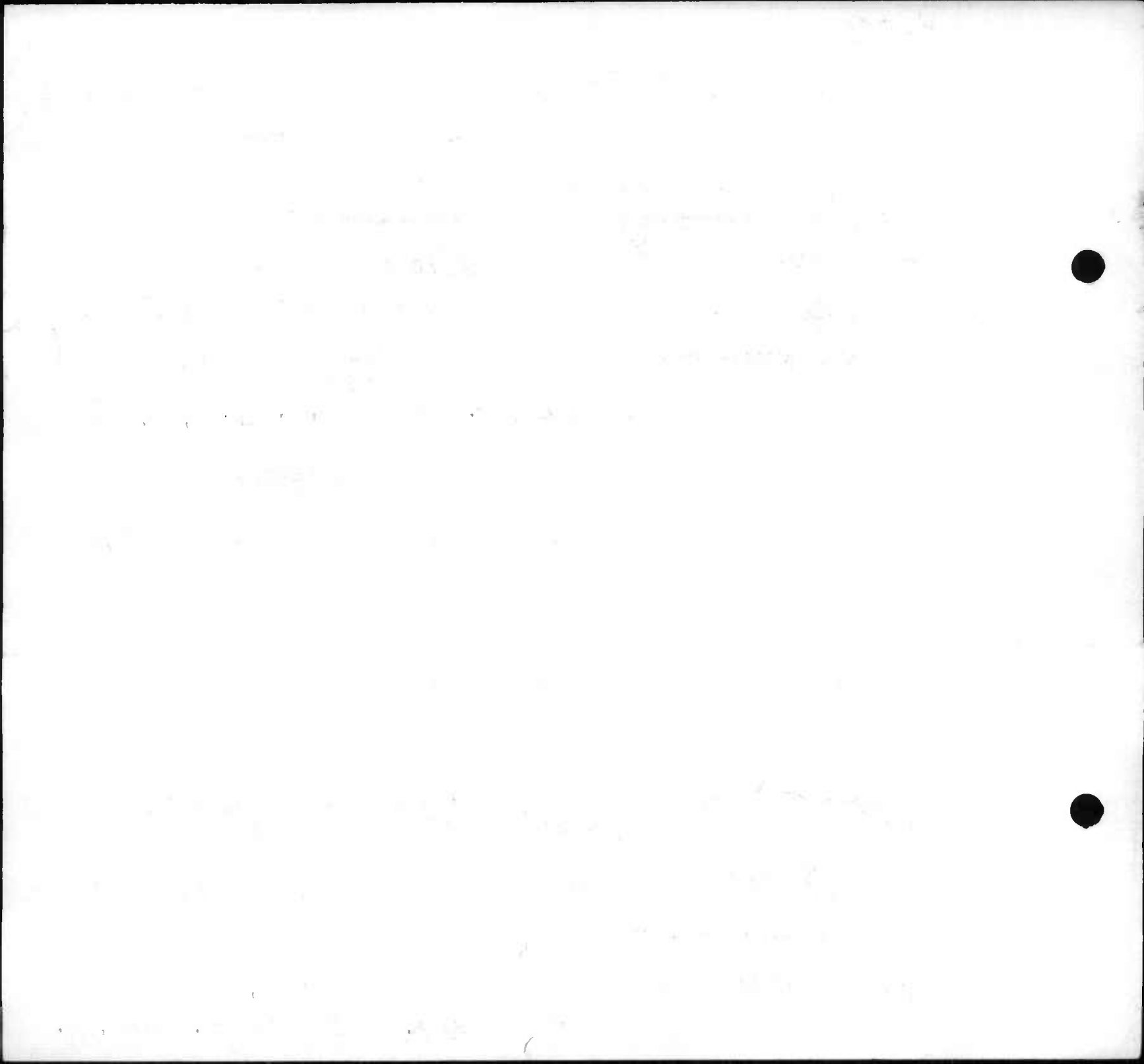
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT											
69 13086					CERTIFICATE OF DEATH						
G-625					Registered No. 69 13086						
1. NAME OF DECEASED (Type or Print) Charles Greason CHARLES GREASON					2. DATE AND HOUR OF DEATH 12/30/69 11:45 P M.						
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MARYLAND GEN. HOSPITAL Maryland General Hospital					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto Dundalk D. STREET ADDRESS (If rural, give location) 710 Wise Avenue						
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 1/6/99	9. AGE (In years last birthday) 70	If Under 1 Yr. Months: Days: Hours: Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tavern Operator			10B. KIND OF BUSINESS OR INDUSTRY Tavern			11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Thomas D. Greason					14. MOTHER'S MAIDEN NAME Louisa Everhardt						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. A216-10-2111		17. INFORMANT Daughter: Mrs. Violet Burke			ADDRESS 710 Wise Avenue Dundalk, Md. 21222			
18. 436.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenio, etc. It means the disease, injury or complication which caused death.) CEREBRAL Thrombosis Generalized Arteriosclerosis Chronic obstructive Airway Disease					CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO					INTERVAL BETWEEN ONSET AND DEATH	
19. DATE OF OPERATION 0					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 12/05 1969 to 12/30 1969 that (I) (we) last saw the deceased alive on 12/30 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Enrique A.					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 12/30/69			
23C. PHYSICIAN'S NAME (Type) ENRIQUE, A.					23D. ADDRESS 827 Linden Ave.						
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/3/70		24C. NAME OF CEMETERY or CREMATORY Bel Air Memorial Gardens			24D. LOCATION (City, town, or county) (State) Bel Air, Maryland				
25A. DATE REC'D BY HEALTH DEPT. JAN 5 1970			25B. NAME OF REGISTRAR Robert E. [Signature]			25C. FUNERAL DIRECTOR John J. Duda			ADDRESS 7922 Wise Ave. Dundalk, Md. 21222		



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

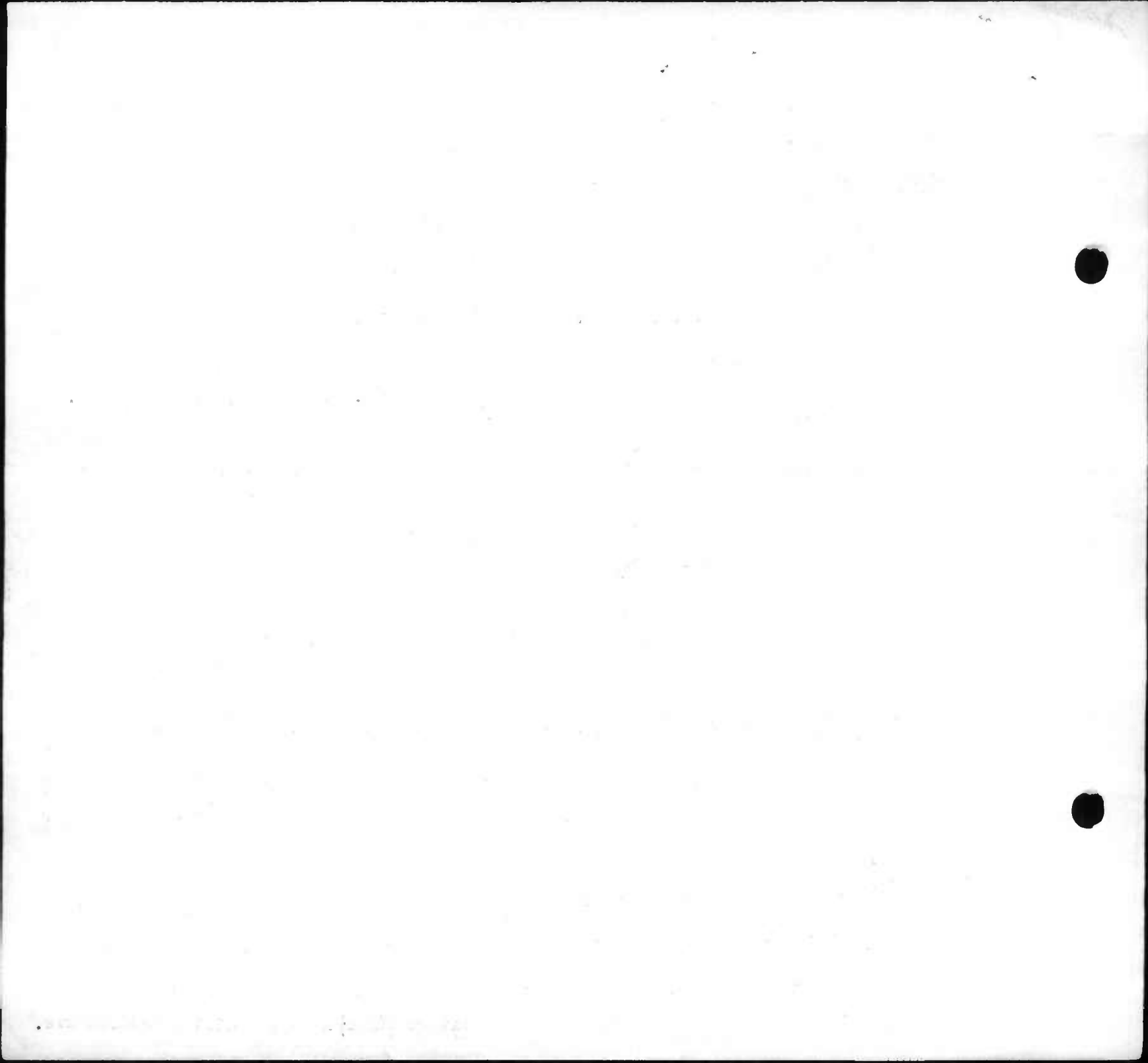
B-526		69 13087		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 69 13087	
BIRTH NO.									
1. NAME OF DECEASED (Type or Print) Catherine Bunger CATHERINE BUNGER					2. DATE AND HOUR OF DEATH Dec 31st 1969 3:00 A.M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) CHURCH HOME AND HOSP. 35 BALTO. MD 21231					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Dundalk D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 1905 Jackson Road				
5. SEX Female		6. RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8.10.07		9. AGE (in years last birthday) 62 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? AMERICA (USA)	
13. FATHER'S NAME Valentine Phillips					14. MOTHER'S MAIDEN NAME Anna Fisher				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 215-24-4051		17. INFORMANT Husband: ADDRESS Mr. George Bunger, Sr. 1905 Jackson Road Dundalk, Md. 21222			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 543 YRS AGO 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CARCINOMA OF THE PANCREAS 20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> No 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from 12/22/1969 to 12/31/1969 that (I) (we) last saw the deceased alive on Dec 31st 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 23A. SIGNATURE [Signature] M) DEGREE 23B. DATE SIGNED DEC. 31st 1969 23C. PHYSICIAN'S NAME (Type) DR. A. F. AZAM MD DEGREE 23D. ADDRESS CHURCH HOME & HOSPITAL BALTO. MD 21231 24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 1/2/70 24C. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cemetery 24D. LOCATION (City, town, or county) Baltimore, Maryland (State) 25A. DATE REC'D BY HEALTH DEPT. JAN 5 1970 25B. NAME OF REGISTRAR Robert J. [Signature] 25C. FUNERAL DIRECTOR John J. Duda ADDRESS 3922 Wise Ave. Dundalk, Md. 21222									



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

E-540		69 13088		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 69 13088		
1. NAME OF DECEASED (Type or Print) HARRY EMMEL					2. DATE AND HOUR OF DEATH 12/31/69 14:45 A.M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 2005					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South Baltimore Gen. Hospital 43					C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
					E. STREET AND NUMBER 2129 Eagle St.					
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/5/22	9. AGE (in years last birthday) 47	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY A.D.M. Corp.		11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? USA.			
13. FATHER'S NAME Charles Emmel					14. MOTHER'S MAIDEN NAME Helen Rose O'Hara					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW II			16. SOCIAL SECURITY NO. 220-05-0672		17. INFORMANT Mrs. Alma Hands, 2139 Eagle St. Patient		ADDRESS SAM E			
18. 2910 H E 885 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DELERIUM TREMENS ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. alcoholism					CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: DELERIUM TREMENS (B) DUE TO, OR AS A CONSEQUENCE OF: alcoholism (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 days many years			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Fracture left Femur							7 days			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NOTIFIED		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) STREET		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 518 Hanover ST.						
21D. TIME OF INJURY (APPROX.) 12/25/69 PM		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Slipped and fall on pavement						
22. I certify that (I) (this hospital) attended the deceased from 12/25 19 69 to 12/31 19 69 that (I) (we) last saw the deceased alive on 12/30 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE Rodolfo Quion M.D.					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 12/31/69		
23C. PHYSICIAN'S NAME (Type) Rodolfo Quion M.D.					23D. ADDRESS South Baltimore Gen. Hosp.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/5/70		24C. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery			24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. JAN 5 1970			25B. NAME OF REGISTRAR John A. ...			25C. FUNERAL DIRECTOR Witzke Funeral Home			ADDRESS 4101 Edmondson Ave.	



W-123

69 13089

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 13089

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Bernetta B. Webster (FOLDER AVE)		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 528 N. Collington Ave.		3. DATE PRONOUNCED DEAD Month Day Year Hour 12 30 69 10:00 a.m.	
6. SEX female		7. RACE white	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 703	
9. DATE OF BIRTH 6-6-1905		10. AGE (In years last birthday) 64 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM R. BOSLEY		14. MOTHER'S MAIDEN NAME ETHEL H. EMINIZER	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		14B. KIND OF BUSINESS OR INDUSTRY DISTILLERY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 217 09 1773G	
18. INFORMANT Wm. R. Spitz - 624 Douglas St.		ADDRESS	
19. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 1-2-70		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) NO			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Minute) m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Werner U. Spitz, M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> Deputy Chief Medical Examiner 12/30/69			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1-2-70	
24C. NAME OF CEMETERY or CREMATORY CEDAR HILL CEM.		24D. LOCATION (City, town, or county) (State) BALTO. MD	
25A. DATE REC'D BY HEALTH DEPT. JAN 5 1970		25B. NAME OF REGISTRAR Robert E. [illegible]	
25C. FUNERAL DIRECTOR Walter [illegible] - 2334 [illegible] St.		ADDRESS	

ACADEMICY (BOM)

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 13080	
<div style="display: flex; justify-content: space-between;"> S-260 69 13090 CERTIFICATE OF DEATH </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) ALBERT LAWRENCE Schweiger			
2. DATE AND HOUR OF DEATH		<div style="display: flex; justify-content: space-between;"> Dec. 31 - 1969 11:45 P.M. </div>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Balto City Hospital		A. STATE Md.		B. COUNTY 2610	
		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 327 S. Clinton St.					
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 12, 1904	
9. AGE (In years last birthday) 65		10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MILLWRIGHT		10B. KIND OF BUSINESS OR INDUSTRY Md.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME ALBERT SCHWEIGER 1ST		14. MOTHER'S MAIDEN NAME ANNIE KELLNER			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 213-075816		17. INFORMANT 3RD ALBERT L. SCHWEIGER	
ADDRESS 3041 Pinewood Ave					
18. 4/10/0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral Hemorrhage (B) Hypertension Art. XL CV DUE TO, OR AS A CONSEQUENCE OF: Atherosclerosis (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION O		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/23 19 68 to 5/29 19 69 , that (I) (we) lost saw the deceased alive on 5/29 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. H. Goodman				23B. DATE SIGNED 1/5/70	
23C. PHYSICIAN'S NAME (Type) JULIUS H GOODMAN MD				23D. ADDRESS 9 S. Hyland Ave	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-5-70		24C. NAME OF CEMETERY OR CREMATORY Oak Lawn	
24D. LOCATION (City, town, or county) (State) Baltimore Md.					
25A. DATE REC'D BY HEALTH DEPT. JAN 5 1970		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Alfred A. Hoffman	
ADDRESS 3218 Hudson St					

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P-355

69 13091

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 13091

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

HERMAN PITTMAN

2. DATE OF DEATH

Known ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

33 JOHNS HOPKINS HOSPITAL

3. DATE PRONOUNCED DEAD

Month

Day

Year

Hour

M.

December 30, 1969

7:30 A.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Maryland

B. COUNTY

1001

6. SEX

Male

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐ NO ☐

9. DATE OF BIRTH

3-30-1925

10. AGE (In years last birthday)

44

11. BIRTHPLACE (State or foreign country)

Withers, N. C.

12. CITIZEN OF WHAT COUNTRY?

E. STREET AND NUMBER

833 E. Chase Street

13. FATHER'S NAME

Jonath Pittman

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Fannie Barnes

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

no

17. SOCIAL SECURITY NO.

217-22-0210

18. INFORMANT

ADDRESS

Fannie Dunn - 833 E. Chase St.

19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

II ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

CAUSE OF DEATH

Craniocerebral Injuries

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

Fatty Metamorphosis of Liver

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

Street

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

Aisquith and Eager Streets 1002

22D. TIME OF INJURY (APPROX.)

12-23-69

Unk. m.

22E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☒

22F. HOW DID INJURY OCCUR?

Subject found on street

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☒

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

Ronald N. Kornblum, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/31/69

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

1-4-70

24C. NAME OF CEMETERY or CREMATORY

Red Hill Cemetery

24D. LOCATION (City, town, or county)

Withers, N. C.

(State)

25A. DATE REC'D BY HEALTH DEPT.

JAN 5 1970

25B. NAME OF REGISTRAR

Robert E. Fisher, Jr.

25C. FUNERAL DIRECTOR

Hillard Funeral Home - Withers, N. C.

ADDRESS

SECRET

RECEIVED

ACADEMY OF SCIENCES

WALLINGTON

1964

1964

1964

S-530

69 13092

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 13092

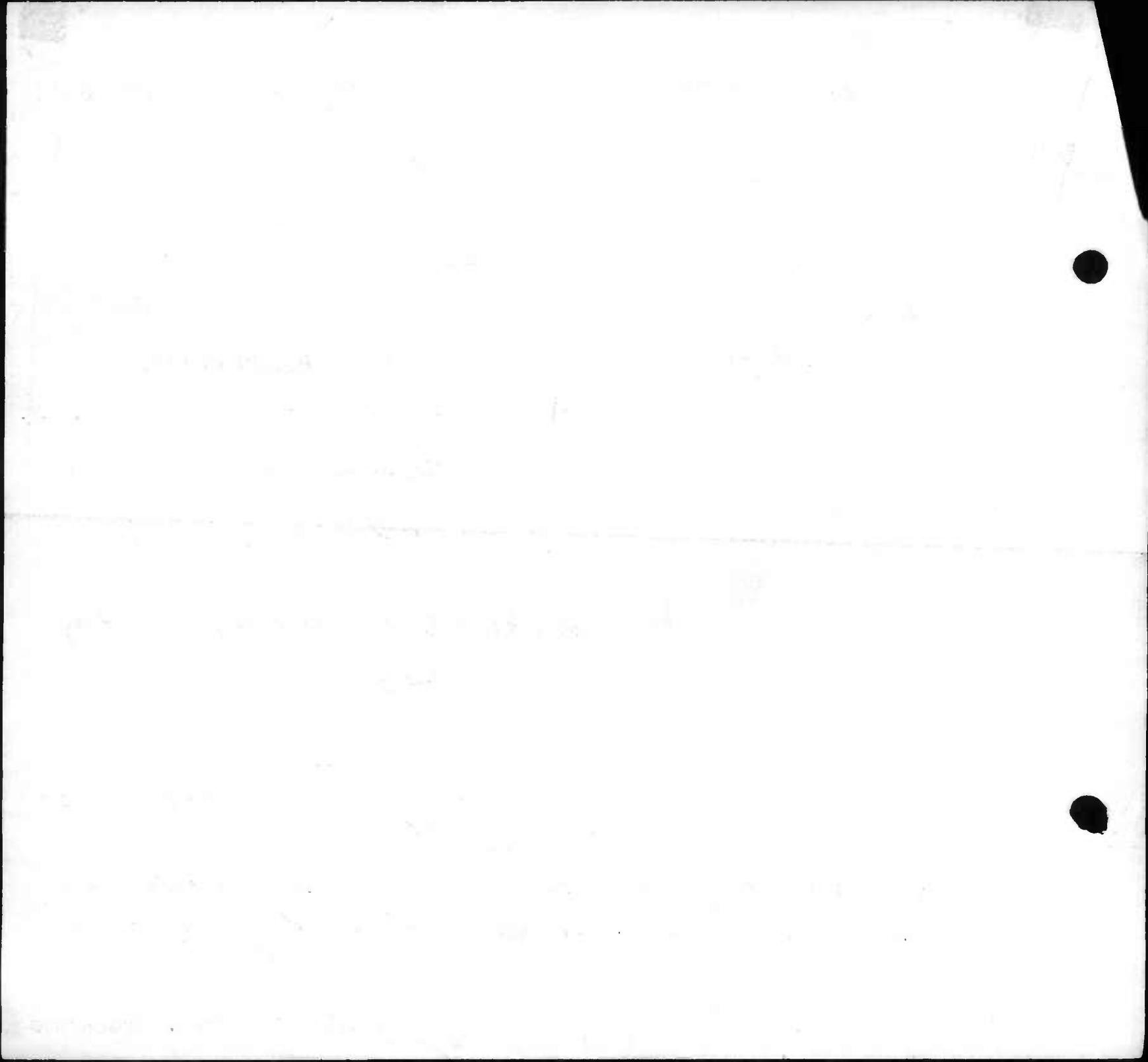
BIRTH NO.

1. NAME OF DECEASED (Type or Print) MARTHA M. SMITH		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 00 1841 Lorman St.		3. DATE PRONOUNCED DEAD Month Day Year Hour 12 28 69 10:55 AM	
6. SEX Female		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 1-15-1919		10. AGE (In years last birthday) 50	
11. BIRTHPLACE (State or foreign country) Hartford Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Willie Jones		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 1502	
15. MOTHER'S MAIDEN NAME Mary Elizabeth Brown		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no	
17. SOCIAL SECURITY NO. 212-22-1370		18. INFORMANT ADDRESS Henrietta Smith - 1841 Lorman St.	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) E966X		CAUSE OF DEATH Multiple stab wounds of chest	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:	
II		(C)	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home	
22D. TIME OF INJURY (APPROX.) Month Day Year Hour 12 28 69 ? m.		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 1841 Lorman St. 1502	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Subj. stabbed by unknown assailant.	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-3-70	
24C. NAME OF CEMETERY or CREMATORY Carver Memorial Park		24D. LOCATION (City, town, or county) (State) Laurel, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 5 1970		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Charles R. Law		ADDRESS 802 Madison Ave.	

ALICE A. DIEHL, W. C. H. G. M. R.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

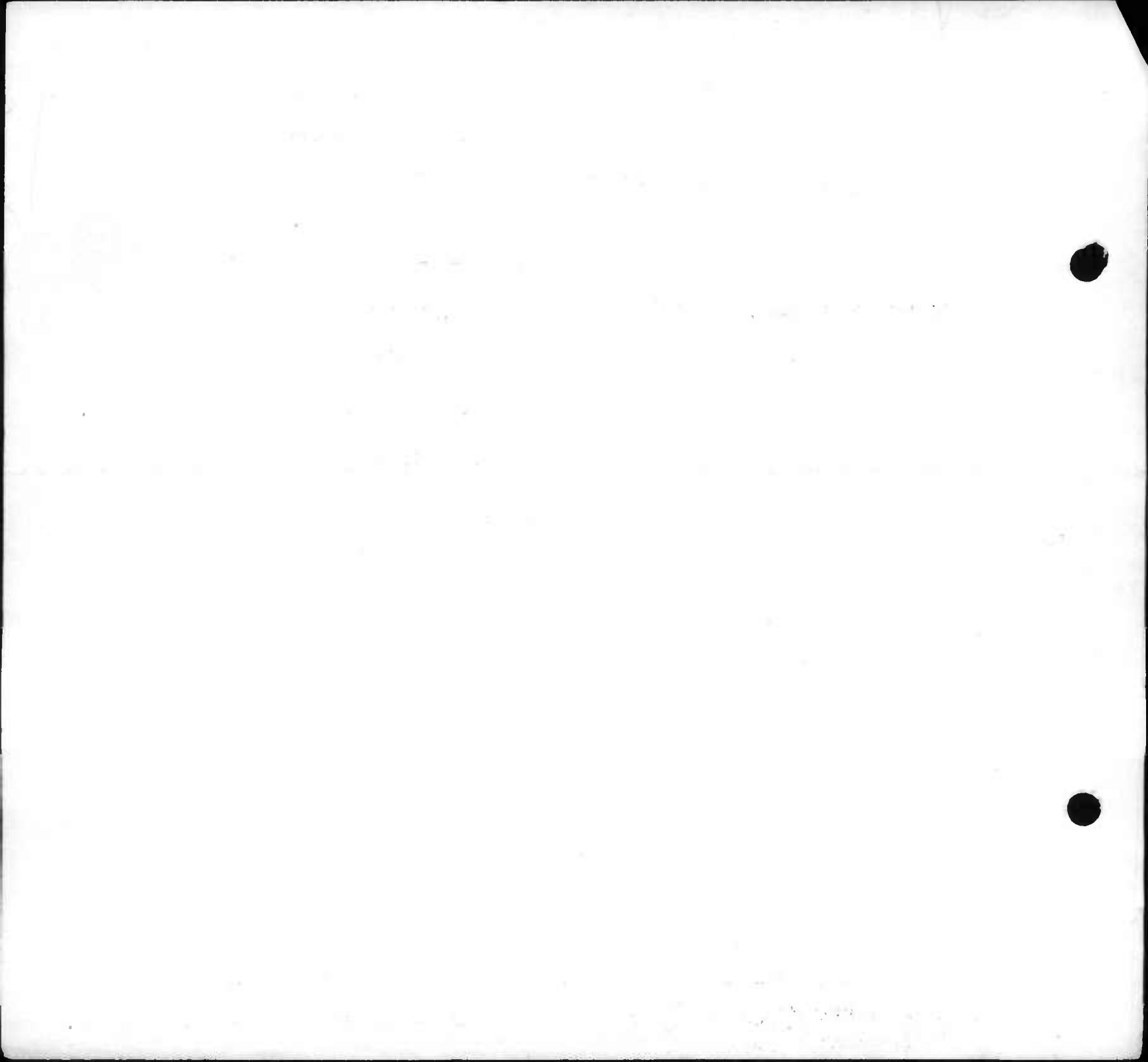
T-512		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 13093	
69 13093		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>MARY M THOMPSON</u>		2. DATE AND HOUR OF DEATH <u>12/25/69</u> <u>11:20</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md</u> B. COUNTY <u>1513</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>SINAI HOSP OF BALTO</u> <u>42</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>2717 Classen Ave.</u>			
5. SEX <u>F</u>	6. RACE <u>NWC</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-9-99</u>	9. AGE (In years lost birthday) <u>70</u>	If Under 1 Yr. Months Days Hours Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MAID</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>HOTEL</u>		11. BIRTHPLACE (State or foreign country) <u>?</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Mitchell Byrd</u>		14. MOTHER'S MAIDEN NAME <u>Sallie Heatherton</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>243-32-5709</u>		17. INFORMANT ADDRESS <u>Mrs. Nancy Wheeler 1420 Amsterdam Ave. N.Y.</u>	
18. <u>4124 I</u> CAUSE OF DEATH		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Days</u> <u>yes.</u>	
(A) IMMEDIATE CAUSE <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF:		(B) <u>AGE</u> DUE TO, OR AS A CONSEQUENCE OF:		(C) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Gastroenteritis, old age</u>				<u>1 day</u>	
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input type="checkbox"/>	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <u>12/24</u> 19 <u>69</u> to <u>12/25</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>12/25</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Lionel E. Gorman MD</u> DEGREE		23B. DATE SIGNED <u>12/25/69</u>		23C. PHYSICIAN'S NAME (Type) <u>DR. DIONISIO B. YORRINO MD</u> DEGREE	
23D. ADDRESS <u>Sinai Hosp. of Balto</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-3-70</u>	
24C. NAME OF CEMETERY or CREMATORY <u>Fercliff Cemetery</u>		24D. LOCATION <u>New York,</u>		(City, town, or county) (State) <u>New York</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 5 1970</u>		25B. NAME OF REGISTRAR <u>James E. [unclear]</u>		25C. FUNERAL DIRECTOR <u>Nutter Funeral Home</u>	
25D. ADDRESS <u>3035 W. North Avenue</u>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

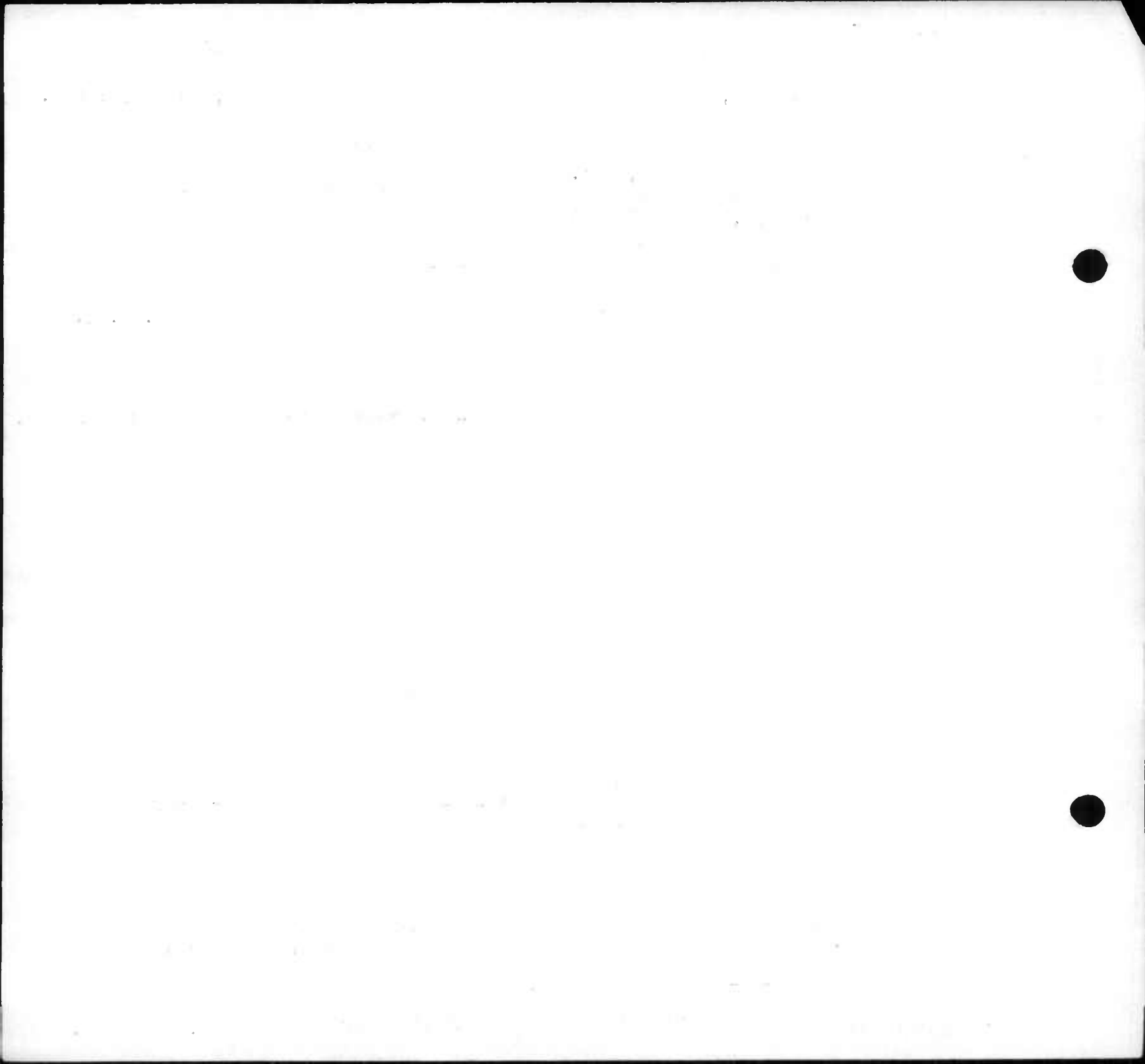
<p>BIRTH NO. M-624 69 13094</p>		<p>BALTIMORE CITY HEALTH DEPARTMENT</p>		<p>CERTIFICATE OF DEATH</p>		<p>REG. NO. 69 13094</p>	
<p>1. NAME OF DECEASED (Type or Print) HARRIET MARSHALL</p>				<p>2. DATE AND HOUR OF DEATH 12/24/69 7:49 A.M.</p>			
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SINAI HOSP. OF BALTO 42</p>				<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY 1510</p>			
<p>5. SEX F 6. RACE NEGRO 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/></p>				<p>8. DATE OF BIRTH 3-30-20 9. AGE (in years last birthday) 49</p>		<p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Histological Tech.</p>	
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Histological Tech.</p>				<p>10B. KIND OF BUSINESS OR INDUSTRY University of Md</p>		<p>11. BIRTHPLACE (State or foreign country) MD, Middletown</p>	
<p>12. CITIZEN OF WHAT COUNTRY? USA</p>				<p>13. FATHER'S NAME Houston R. Jackson</p>			
<p>14. MOTHER'S MAIDEN NAME Marion Johnson</p>				<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No</p>			
<p>16. SOCIAL SECURITY NO.</p>				<p>17. INFORMANT Dr. Houston R. Jackson ADDRESS 565 Prestman St.</p>			
<p>18. CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Acute MI + Tangle made 3 hrs</p> <p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. H A S C U D</p>				<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 17 yrs.</p>			
<p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>							
<p>19A. DATE OF OPERATION 2</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>		<p>20A. AUTOPSY? (Yes or No) YES</p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (Month (Day) (Year) (Hour) (Approx.))</p>	
<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>		<p>22. I certify that (I) (this hospital) attended the deceased from Dec 24 19 69 to Dec 24 19 69 that (I) (we) last saw the deceased alive on Dec 24 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE E. T. Sutton</p>				<p>23B. DATE SIGNED 12-24-69</p>		<p>23C. PHYSICIAN'S NAME (Type) ELLA T. SUTTON</p>	
<p>23D. ADDRESS SINAI HOSPITAL</p>				<p>24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 12-29-69 24C. NAME of CEMETERY or CREMATORY Mt Zion Cemetery 24D. LOCATION Baltimore Co., Maryland</p>			
<p>25A. DATE REC'D BY HEALTH DEPT. JAN 5 1970 25B. NAME of REGISTRAR Robert E. Taylor, Md. 25C. FUNERAL DIRECTOR Nutter Funeral Home ADDRESS 3035 W. North Ave.</p>				<p>VS 150-REV. 1/1/68</p>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

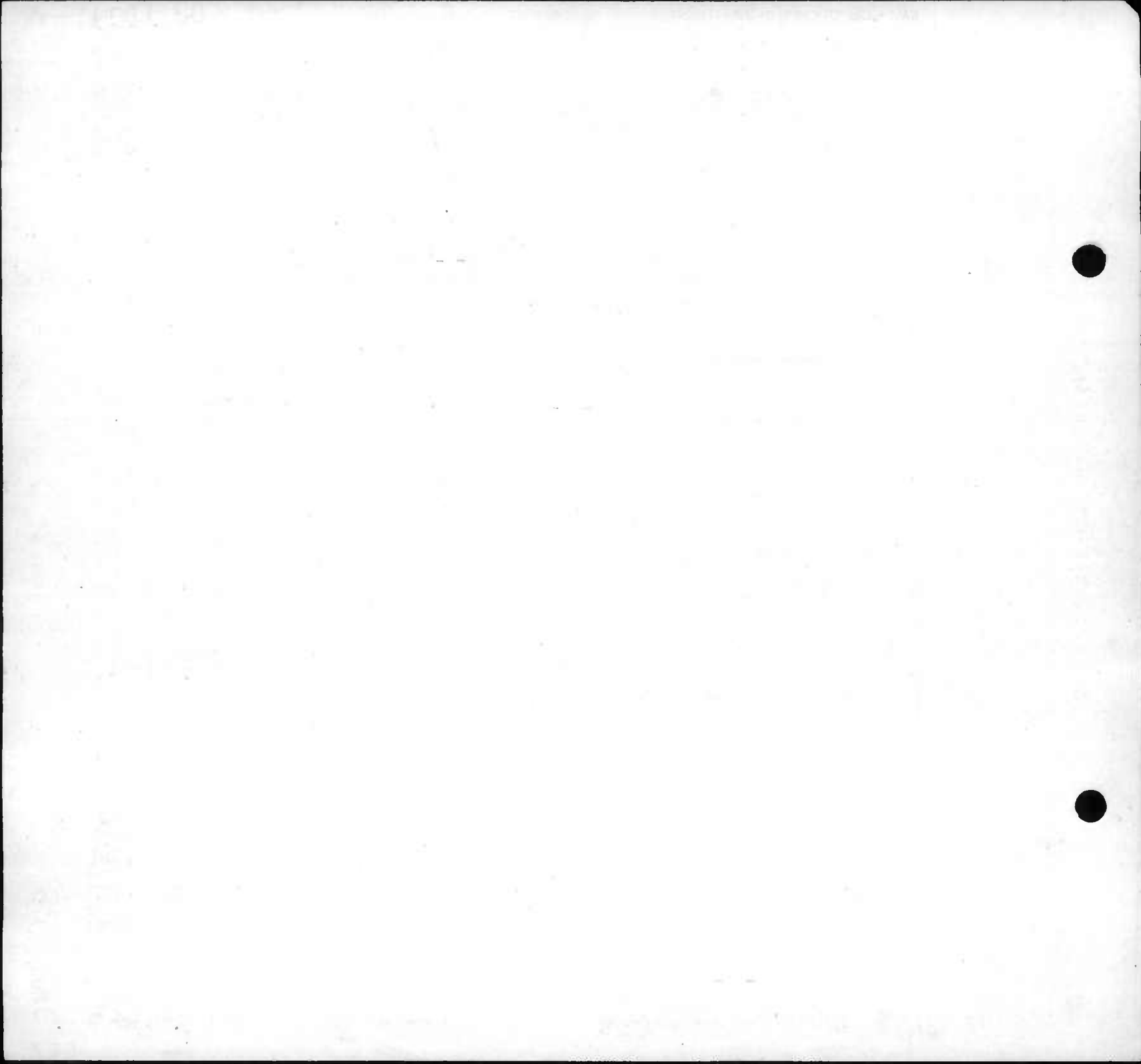
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 13095	
69 13095 CERTIFICATE OF DEATH					
BIRTH NO. H-125					
1. NAME OF DECEASED (Type or Print) Hopkins, Millis				2. DATE AND HOUR OF DEATH December 26, 1969 10:20 a.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Provident Hospital, Inc. 1514 Division Street Baltimore, Maryland 21217				A. STATE Maryland B. COUNTY 1403	
5. SEX Female				6. RACE Negro	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 9-27-24	
9. AGE (In years last birthday) 45				10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic				10B. KIND OF BUSINESS OR INDUSTRY Pvt Family	
11. BIRTHPLACE (State or foreign country) North Carolina				12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Boston Tetterson				14. MOTHER'S MAIDEN NAME Eva Little	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Bertha Hamilton				ADDRESS 321 14th Place N.E. Wash.	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Hepato renal failure					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12-24-69 19 to 12-26-69 19 that (I) (we) lost saw the deceased alive on 12-26-69 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. [Signature]				23B. DATE SIGNED 12-26-69	
23C. PHYSICIAN'S NAME (Type) Dr. [Signature]				23D. ADDRESS 1514 Division Street Provident Hospital, Baltimore, Maryland	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-31-69		24C. NAME OF CEMETERY or CREMATORY Mt Auburn Cem.	
24D. LOCATION Baltimore		24E. (City, town, or county) Md		24F. (State)	
25A. DATE REC'D BY HEALTH DEPT. JAN 5 1970				25B. NAME OF REGISTRAR [Signature]	
25C. FUNERAL DIRECTOR Nutter Funeral Home				ADDRESS 3035 W. North Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

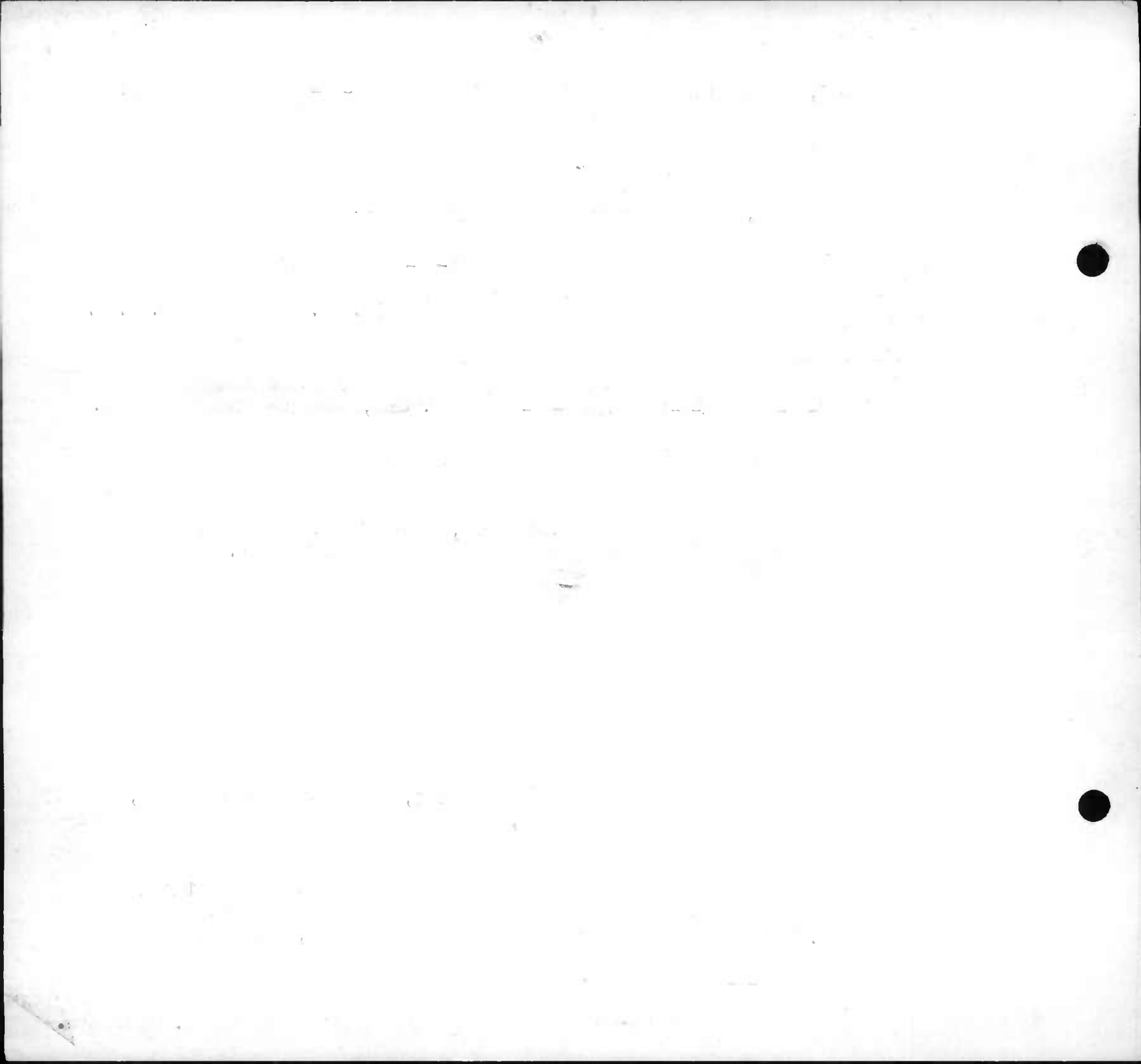
BALTIMORE CITY HEALTH DEPARTMENT				69 13096	
J-520				69 13096	
BIRTH NO.				REG. NO.	
1. NAME OF DECEASED (Type or Print) Jones Anne			2. DATE AND HOUR OF DEATH 12-28-69 5:45 AM		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Lutheran Hosp. Tal.			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 1538		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER 3406 Bateman Ave.					
5. SEX F	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-1-1878	9. AGE (In years last birthday) 91	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10B. KIND OF BUSINESS OR INDUSTRY Mt Calvary Clergy Home		11. BIRTHPLACE (State or foreign Country) USA	
13. FATHER'S NAME James Jones			14. MOTHER'S MAIDEN NAME Mathilda ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-36-4253		17. INFORMANT ADDRESS Mrs. Jacqueline Montague 3809 Bowers Ave.	
18. 436.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Cerebro-Vascular Accident.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebro-Vascular Accident. (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 to 19 , that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Violeta B. Gamarras R. MD				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) VIOLETA B. GAMARRAS R. MD				23D. ADDRESS 730 Ashburton St Bal Md	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-31-69		24C. NAME OF CEMETERY OR CREMATORY Mt Auburn Cemetery	
24D. LOCATION (City, town, or county) Baltimore		24E. STATE Md			
25A. DATE REC'D BY HEALTH DEPT. JAN 3 1970		25B. NAME OF REGISTRAR Robert E. Seabury		25C. FUNERAL DIRECTOR ADDRESS Nutter Funeral Home 3035 W. North Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> L-000 69 13097 </div>		<div style="display: flex; justify-content: space-between;"> BIRTH NO. REG. NO. 69 13097 </div>	
1. NAME OF DECEASED (Type or Print) LEE, Robert Hall		2. DATE AND HOUR OF DEATH <div style="display: flex; justify-content: space-between;"> 12-28-69 3:15 A M. </div>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <div style="display: flex; align-items: center;"> 23 <div> Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218 </div> </div>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1601 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1109 Winchester Street	
5. SEX Male	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-26-95 9. AGE (In years last birthday) 74
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Mathews Co. Va.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Morris Mathews		14. MOTHER'S MAIDEN NAME Laura Hall	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 10-27-17 to 6-5-19		16. SOCIAL SECURITY NO. 217-03-87-40	
17. INFORMANT Mrs. Ossie Williams		ADDRESS 251 Robert St.	
18. 43291 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) PNEUMONIA ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. THROMBOSIS, INTERNAL CAROTID ARTERY ON THE RIGHT.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that MD (this hospital) attended the deceased from December 1, 19 69 to December 28, 19 69 , that MD (we) lost saw the deceased alive on December 28, 19 69 and that in MD (our) opinion death occurred on the date and hour and from the causes stated above. MD (We) (did) (did not) view the body after death.			
23A. SIGNATURE Michael G. Hayes, M.D.			23B. DATE SIGNED 12/28/69
23C. PHYSICIAN'S NAME (Type) MICHAEL G. HAYES		23D. ADDRESS 3900 Loch Raven Boulevard Baltimore, Maryland 21218	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-2-70	
24C. NAME OF CEMETERY or CREMATORY Baltimore National Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT. JAN 5 1970		25B. NAME OF REGISTRAR Robert E. Hayes	
25C. FUNERAL DIRECTOR Notter Funeral Home		ADDRESS 3035 W. North Ave.	



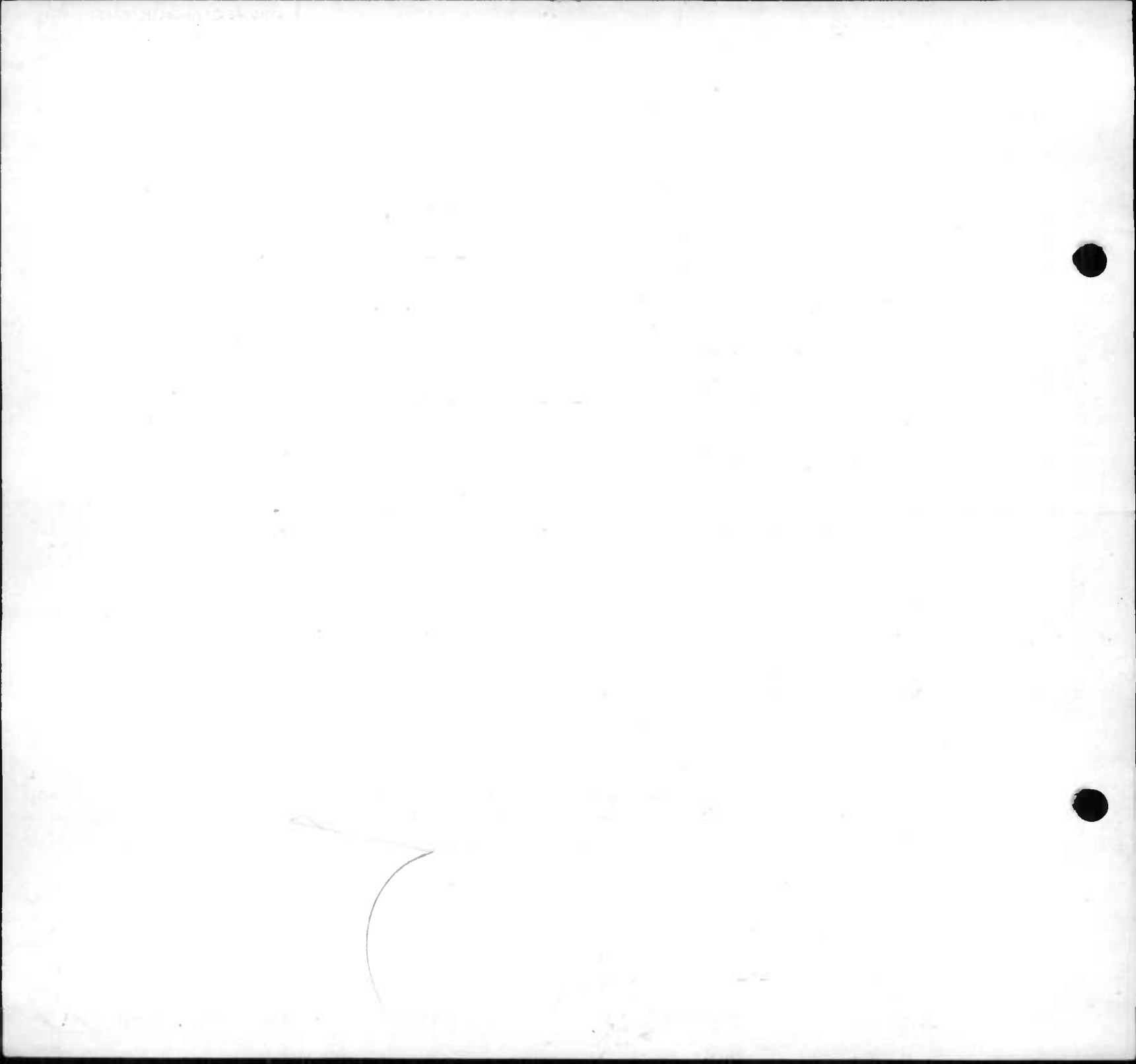
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

5-155		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 13098	
BIRTH NO. 69 13098		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Shipman, Esther		2. DATE AND HOUR OF DEATH 5 ³⁰ AM 12/31/69			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Univ. Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE 807 Brice St. Maryland 1604 C. CITY OR TOWN Belt Rd D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 807 Brice St.			
5. SEX Female	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/13/23	9. AGE (in years last birthday) 46	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY Regal Laundry		11. BIRTHPLACE (State or foreign country) North Carolina	
12. CITIZEN OF WHAT COUNTRY USA		13. FATHER'S NAME Alton Shipman			
14. MOTHER'S MAIDEN NAME Mariah Bullard		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 200-18-4922		17. INFORMANT ADDRESS Miss Florince R. Shipman 807 Brice Street			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pulmonary Sarcoidosis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pulmonary Sarcoidosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 yrs.	
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) _____			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/1/69 to 12/31/69 that (I) (we) last saw the deceased alive on 12/30/69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Michael Frenn MD		23B. DATE SIGNED 2/3/69		23C. PHYSICIAN'S NAME (Type) Michael Frenn MD	
23D. ADDRESS Univ. Hosp		23E. ATTENDING PHYSICIAN <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-4-70		24C. NAME OF CEMETERY OR CREMATORY Millikan Cemetery	
24D. LOCATION Whiteville		24E. (City, town, or county) N. Carolina			
25A. DATE REC'D BY HEALTH DEPT. JAN 5 1970		25B. NAME OF REGISTRAR Robert E. Talley		25C. FUNERAL DIRECTOR Nutter Funeral Home 3035 W. North Avenue	

2 p. 100

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

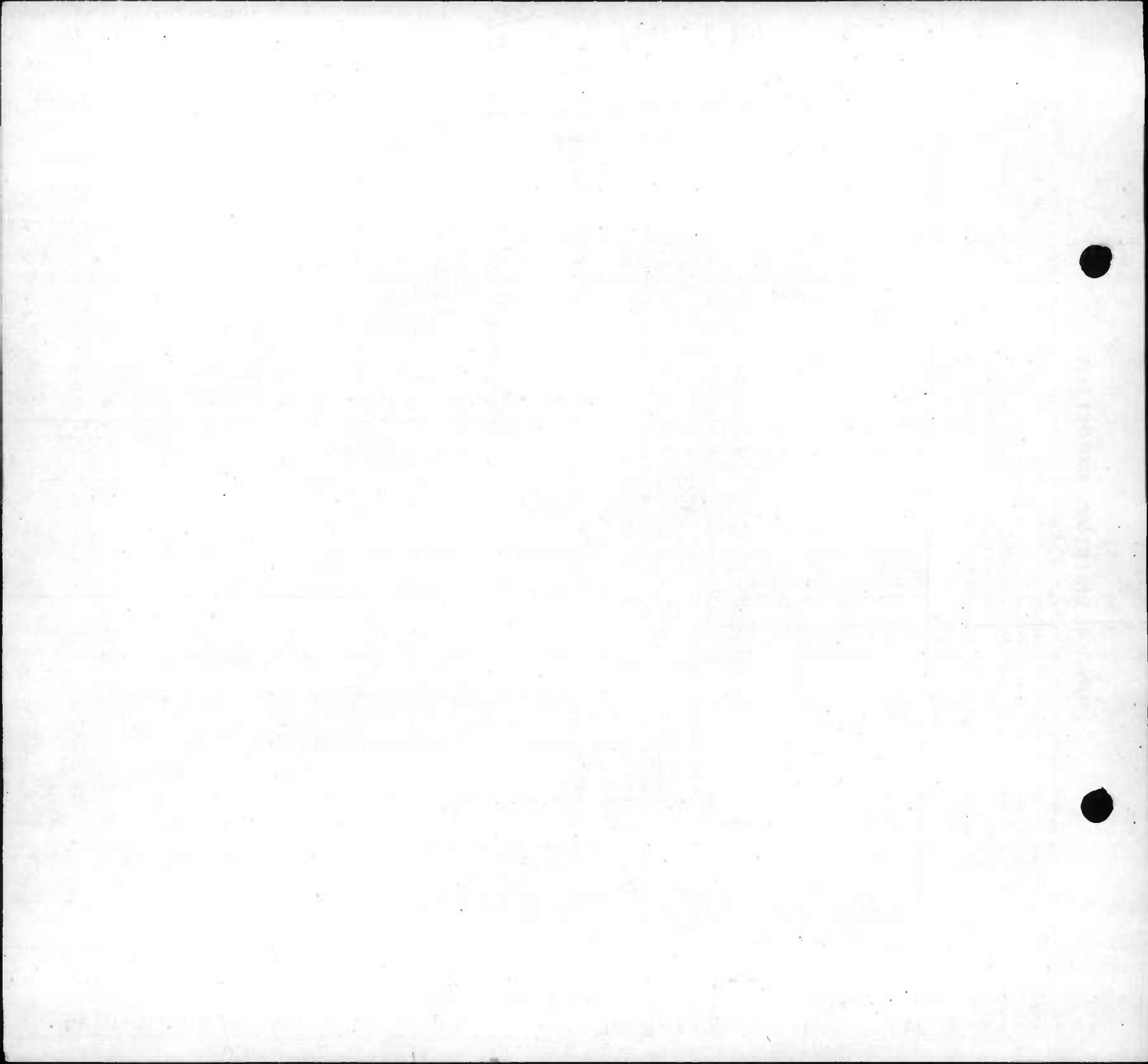
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 13099	
BIRTH NO. 69 13099		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Ruth B. Mc Abee		2. DATE AND HOUR OF DEATH 12/31/69		2:45 am M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 Pleasant Manor Convalescent Home		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE 8. COUNTY Maryland C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1225 W. Lafayette Avenue			
5. SEX F	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-20-89	9. AGE (In years last birthday) 80	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Music Teacher		10B. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) S. C.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Rev. I. S. Lee			
14. MOTHER'S MAIDEN NAME Harriet Duffield		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 214-40-7590		17. INFORMANT ADDRESS Dr. C. Dudley Lee 3000 Carlisle Ave			
18. 433,91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Recurrent Cerebral Thromboses (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral Arteriosclerosis (B) DUE TO, OR AS A CONSEQUENCE OF: (C)..... APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year Several years		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Chronic Hypertension 2 months			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 12 19 69 to Dec 31 19 69, that (I) (we) last saw the deceased alive on Dec 26 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Roland T. Smoot		23B. DATE SIGNED 1/2/70		23C. PHYSICIAN'S NAME (Type) ROLAND T. SMOOT, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-3-70		24C. NAME OF CEMETERY OR CREMATORY Mt Auburn Cemetery	
24D. LOCATION (City, town, or county) Baltimore		24E. STATE Md		24F. ADDRESS Nutter Funeral Home 3035 W. North Ave.	
25A. DATE REC'D BY HEALTH DEPT. JAN 5 1970		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT																								
69 13100					CERTIFICATE OF DEATH					REG. NO. 69 13100														
BIRTH NO. <div style="font-size: 2em; font-family: cursive;">R-534</div>										2. DATE AND HOUR OF DEATH <div style="font-size: 1.5em; font-family: cursive;">Dec. 31, 1969 9:10 A.M.</div>														
1. NAME OF DECEASED (Type or Print) <div style="font-size: 1.5em; font-family: cursive;">FANNIE RANDALL J</div>										4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <div style="font-size: 1.5em; font-family: cursive;">Md</div> B. COUNTY <div style="font-size: 1.5em; font-family: cursive;">2710</div>														
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <div style="font-size: 1.5em; font-family: cursive;">9 MONTEBELLO STATE HOSPITAL</div>										C. CITY OR TOWN <div style="font-size: 1.5em; font-family: cursive;">Baltimore</div> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>														
E. STREET AND NUMBER <div style="font-size: 1.5em; font-family: cursive;">4529 Saint George Ave.</div>																								
5. SEX <div style="font-size: 1.5em; font-family: cursive;">F</div>		6. RACE <div style="font-size: 1.5em; font-family: cursive;">C</div>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <div style="font-size: 1.5em; font-family: cursive;">2-9-11</div>		9. AGE (In years last birthday) <div style="font-size: 1.5em; font-family: cursive;">58</div>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.														
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <div style="font-size: 1.5em; font-family: cursive;">Cook</div>					10B. KIND OF BUSINESS OR INDUSTRY <div style="font-size: 1.5em; font-family: cursive;">Public & Pvt</div>					11. BIRTHPLACE (State or foreign country) <div style="font-size: 1.5em; font-family: cursive;">Md</div>					12. CITIZEN OF WHAT COUNTRY? <div style="font-size: 1.5em; font-family: cursive;">USA</div>									
13. FATHER'S NAME <div style="font-size: 1.5em; font-family: cursive;">?</div>										14. MOTHER'S MAIDEN NAME <div style="font-size: 1.5em; font-family: cursive;">?</div>														
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <div style="font-size: 1.5em; font-family: cursive;">No</div>					16. SOCIAL SECURITY NO. <div style="font-size: 1.5em; font-family: cursive;">215-14-5007</div>					17. INFORMANT <div style="font-size: 1.5em; font-family: cursive;">Miss Elizabeth Johnson</div> ADDRESS <div style="font-size: 1.5em; font-family: cursive;">4529 Saint George Ave.</div>														
18. I <div style="font-size: 1.5em; font-family: cursive;">174X I</div> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <div style="font-size: 1.5em; font-family: cursive;">CAUSE OF DEATH</div>										<div style="font-size: 1.5em; font-family: cursive;">Carcinoma of breast with generalized metastases</div>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <div style="font-size: 1.5em; font-family: cursive;">5 years</div>				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.										(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF <div style="font-size: 1.5em; font-family: cursive;">generalized metastases</div>														
(B) DUE TO, OR AS A CONSEQUENCE OF:																								
(C) DUE TO, OR AS A CONSEQUENCE OF:																								
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).																								
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No)					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)														
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?														
22. I certify that (I) (this hospital) attended the deceased from <div style="font-size: 1.5em; font-family: cursive;">Dec. 9</div> 19 <div style="font-size: 1.5em; font-family: cursive;">69</div> to <div style="font-size: 1.5em; font-family: cursive;">Dec. 31</div> 19 <div style="font-size: 1.5em; font-family: cursive;">69</div> , that (I) (we) last saw the deceased alive on <div style="font-size: 1.5em; font-family: cursive;">Dec. 31</div> 19 <div style="font-size: 1.5em; font-family: cursive;">69</div> and that in (my) (our) opinion death occurred on the date <div style="font-size: 1.5em; font-family: cursive;">and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</div>																								
23A. SIGNATURE <div style="font-size: 1.5em; font-family: cursive;">Kuo-Siong Tan, M.D.</div>										23B. DATE SIGNED <div style="font-size: 1.5em; font-family: cursive;">12-31-69</div>					23C. PHYSICIAN'S NAME (Type) <div style="font-size: 1.5em; font-family: cursive;">Kuo-Siong Tan, M.D.</div>					23D. ADDRESS				
24A. BURIAL CREMATION, REMOVAL (Specify) <div style="font-size: 1.5em; font-family: cursive;">Burial</div>					24B. DATE <div style="font-size: 1.5em; font-family: cursive;">1-3-70</div>					24C. NAME OF CEMETERY OR CREMATORY <div style="font-size: 1.5em; font-family: cursive;">Arbutus Memorial Park</div>					24D. LOCATION (City, town, or county) (State) <div style="font-size: 1.5em; font-family: cursive;">Baltimore Co., Md</div>									
25A. DATE REC'D BY HEALTH DEPT. <div style="font-size: 1.5em; font-family: cursive;">JAN 5 1970</div>					25B. NAME OF REGISTRAR <div style="font-size: 1.5em; font-family: cursive;">Robert E. Taylor, M.D.</div>					25C. FUNERAL DIRECTOR <div style="font-size: 1.5em; font-family: cursive;">Nutter Funeral Home</div>					ADDRESS <div style="font-size: 1.5em; font-family: cursive;">3035 W. North Ave.</div>									



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-216 69 13101		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 69 13101	
CERTIFICATE OF DEATH					
BIRTH NO. <u>M-216</u>		M.E. CASE NO. <u>69-13101</u>			
1. NAME OF DECEASED (Type or Print) <u>McPherson, Mrs. Victoria W.</u>		2. DATE AND HOUR OF DEATH <u>12-24-68</u> <u>8:40</u> A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>48 Maryland General Hospital</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>1504</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>214 Walbrook Ave.</u>			
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>married</u>	8. DATE OF BIRTH <u>9-7-02</u>	9. AGE (In years last birthday) <u>67</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Pvt Family</u>		11. BIRTHPLACE (State or foreign country) <u>Va.</u>	
13. FATHER'S NAME <u>James Maglone</u>		14. MOTHER'S MAIDEN NAME <u>Sallie Giddens</u>		12. CITIZEN OF WHAT COUNTRY? <u>MD USA</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-30-5088</u>		17. INFORMANT <u>Joseph A. McPherson</u> ADDRESS <u>214 Walbrook Ave.</u>	
18. <u>20-0-9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO <u>Pulmonary Infarction</u> (B) DUE TO <u>Congestive Failure</u> (C) <u>Diabetes Mellitus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>hours</u> <u>1-2 days</u> <u>years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (he) (this hospital) attended the deceased from <u>12-22</u> 19 <u>68</u> to <u>12-24</u> 19 <u>68</u> that (I) (we) last saw the deceased alive on <u>12-24</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <u>J. S. Kim</u> M.D.				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <u>J. S. Kim</u> M.D.				23D. ADDRESS <u>Maryland General Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12-27-69</u>		24C. NAME OF CEMETERY or CREMATORY <u>Arbutus Memorial Park</u>	
24D. LOCATION (City, town, or county) <u>Balto. Co.</u>		(State) <u>Md</u>			
25A. DATE RECEIVED BY HEALTH DEPT. <u>JAN 3 1970</u>		25B. NAME OF REGISTRAR <u>W. E. J. Kim</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Nutter Funeral Home 3035 W. North Ave.</u>	

CONFIDENTIAL

CONFIDENTIAL
2156

1

69 13102

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 13102

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

ROY V. STIMMS

2. DATE
OF DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

12

23

69

6:33 PM.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

46 Lutheran Hospital

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

Dec.

23

1969

6:33 PM.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

Balto.

YES ☒NO ☐

6. SEX

Male

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

9. DATE OF BIRTH

11-14-50

10. AGE (In years
last birthday)

19

11. Under 1 Yr. 12 Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

1804 N. Appleton St.

11. BIRTHPLACE (State or foreign country)

Md

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

James L. Simms

14. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Elvira Jones

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL
SECURITY NO.

218-56-0234

18. INFORMANT

ADDRESS

Carolyn Simms Johnson 1804 N. Appelton St.

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) IMMEDIATE CAUSE Multiple traumatic injuries
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

YES

22A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

St.

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

1600 blk. n. Fulton 73' N. of Baker

22D. TIME
OF INJURY
(APPROX.)

12 23

69 6:30

22E. INJURY OCCURRED
WHILE AT WORK ☐ NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Subject pedestrian struck by truck

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Ronald N. Kornblum, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/24/69

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

12-29-69

24C. NAME of CEMETERY or CREMATORY

Mt Auburn Cemetery

24D. LOCATION (City, town, or county)

Baltimore

(State)

Md

25A. DATE REC'D BY HEALTH DEPT.

JAN 5 1970

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

ADDRESS

Nutter Funeral Home 3035 W. North Ave.

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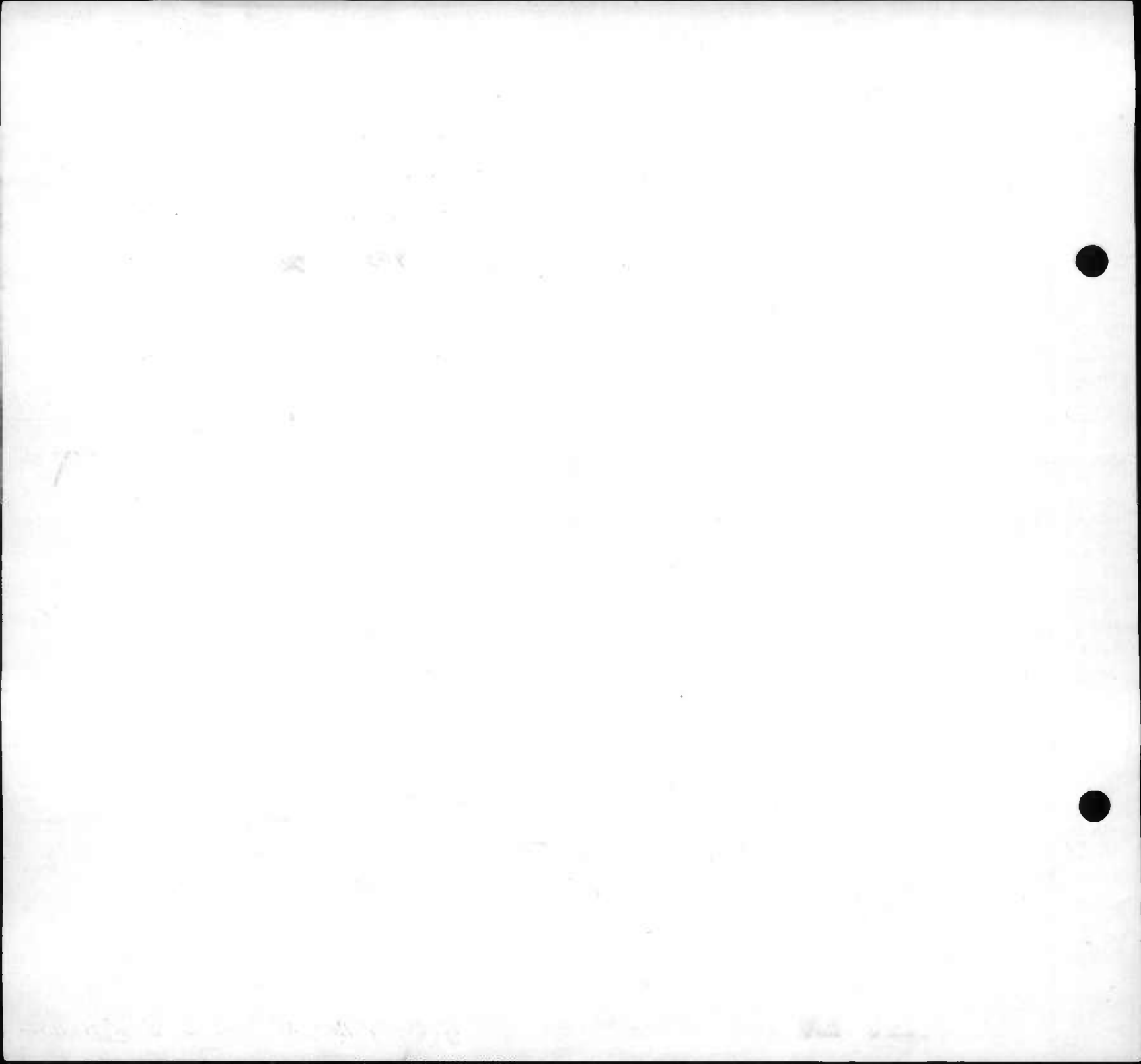
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10-11-11

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 13103	
0-520 69 13103		CERTIFICATE OF DEATH	
BIRTH NO. A.		2. DATE AND HOUR OF DEATH 12-31-69 7:15 P.M.	
1. NAME OF DECEASED (Type or Print) Marion Owens		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY CITY	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Harbor View Nursing Home 90 1213 Light St		C. CITY OR TOWN BALTO D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 3411 Gwyns Falls Parkway		5. SEX F 6. RACE C 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 7/18/1903 9. AGE (In years last birthday) 66		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework	
11. BIRTHPLACE (State or foreign country) MD		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME PLUMER GOODWIN		14. MOTHER'S MAIDEN NAME (Last name) DORCAS GILBERT	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-18-7029	
17. INFORMANT LEON OWENS		ADDRESS 3411 Gwyns Falls PKW	
18. 485X1 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that the (this hospital) attended the deceased from 10/14 19 68 to 12/31 19 69 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) We (we) (did) (did not) view the body after death.			
23A. SIGNATURE A. C. Alenzaros		23B. DATE SIGNED 1/2/70	
23C. PHYSICIAN'S NAME (Type) A. C. ALENZAROS, M.D.		23D. ADDRESS 1709 ST. Paul Street	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1/3/70	
24C. NAME OF CEMETERY OR CREMATORY Mt AUBURN CEM.		24D. LOCATION (City, town, or county) (State) BALTO. MD.	
25A. DATE REC'D BY HEALTH DEPT. JAN 5 1970		25B. NAME OF REGISTRAR Wm C MARCH	
25C. FUNERAL DIRECTOR Wm C MARCH		ADDRESS 928 E. NORTH AVE	



C-632 69 13104 BALTIMORE CITY HEALTH DEPARTMENT
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 69 13104

1. NAME OF DECEASED (Type or Print) Lawrence Courts		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 46 Lutheran Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 12 30 69 6:00 a.m.	
6. SEX male		7. RACE colored	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1304	
9. DATE OF BIRTH Jan. 20, 1932		10. AGE (In years last birthday) 37	
11. BIRTHPLACE (State or foreign country) Reidsville N.C.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Sampson Courts		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attendant	
15. MOTHER'S MAIDEN NAME Annie Neil		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO.		18. INFORMANT Mamie Graves	
19. E 9551X		ADDRESS 351 Bernice Ave	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 12/29/69		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 2273 Reisterstown Rd. 1304			
22D. TIME OF INJURY (APPROX.) 12 29 69 11:08 p.m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? shot self			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Werner U. Spitz, M.D.		DATE SIGNED 12/30/69	
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 1/3/70	
24C. NAME OF CEMETERY or CREMATORY Wilkinson Cem. Balto. Md.		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D AT HEALTH DEPT. 1/3/70		25B. NAME OF REGISTRAR Robert E. Fisher	
25C. FUNERAL DIRECTOR Williams Funeral Home		ADDRESS 3194 Schickel St.	

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

George C. Davis

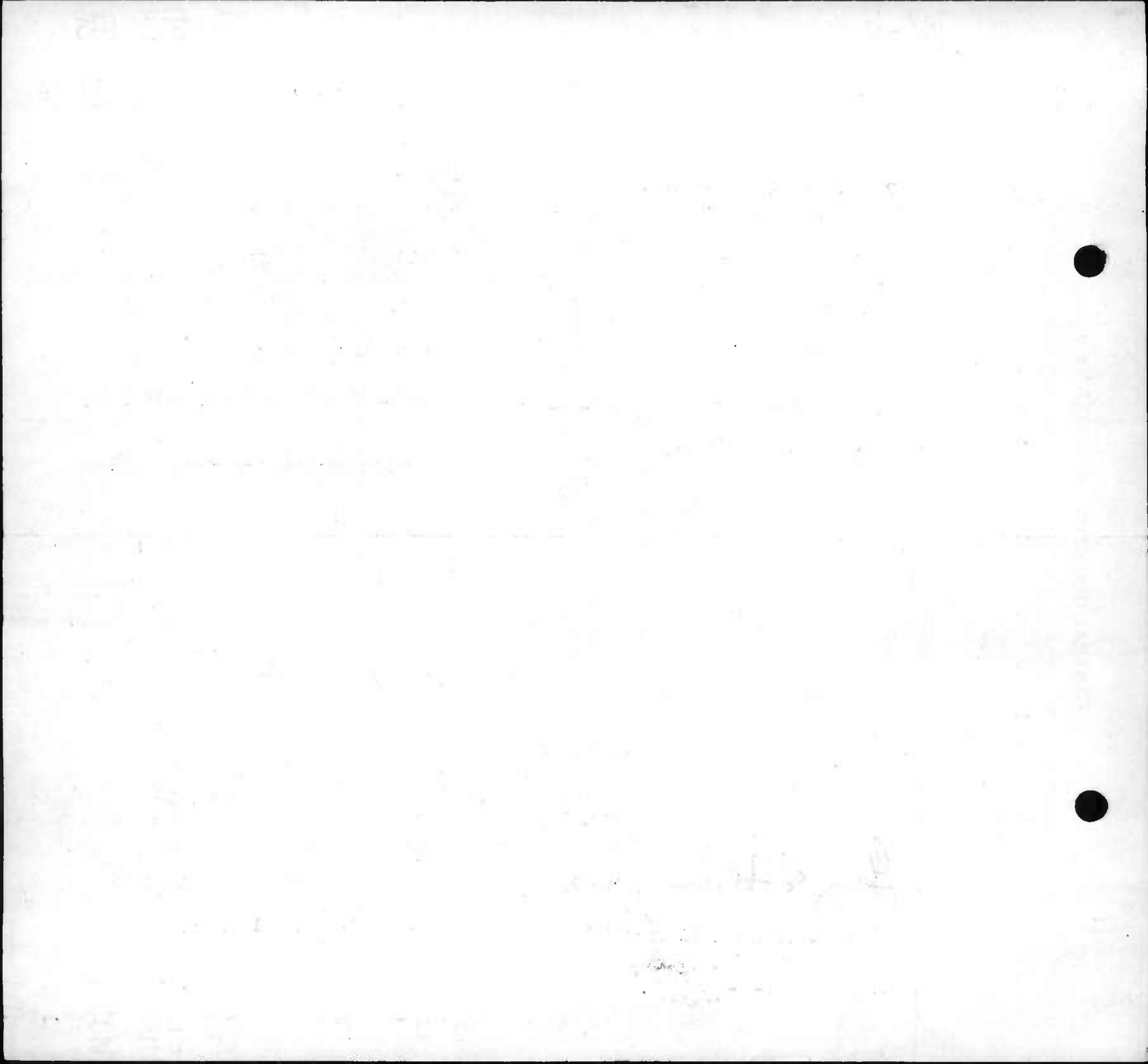
1895

George C. Davis
1895

FUNERAL DIRECTOR: IMPORTANT

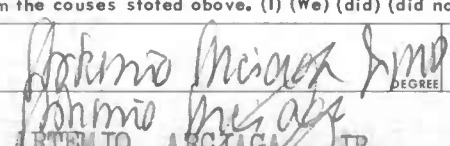
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

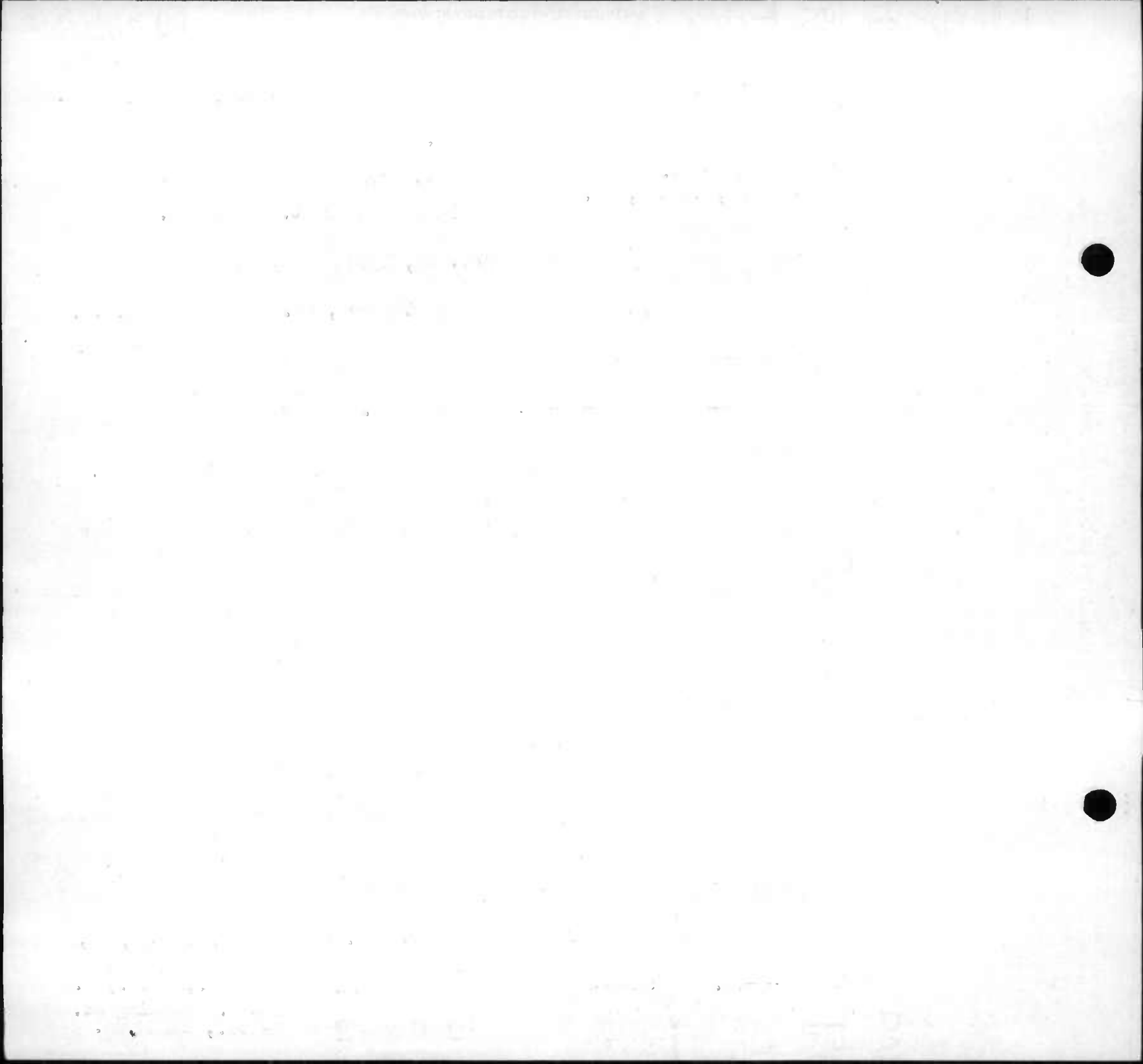
BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 13105	
BIRTH NO. N-242		69 13105 CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Randolph Grant Nichols		2. DATE AND HOUR OF DEATH Dec. 30, 1969 10 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Va. B. COUNTY V-43	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) US Public Health Service Hospital 3100 Wyman Parkway		C. CITY OR TOWN Alexandria D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX M 6. RACE W 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER 5907 Ridgeview Drive	
8. DATE OF BIRTH 2/3/20 9. AGE (In years last birthday) 49		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer	
11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Wilmer Nichols		14. MOTHER'S MAIDEN NAME Agnes Booth Risdon	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 1942-1945 -USN		16. SOCIAL SECURITY NO. 577-18-7796	
17. INFORMANT Records- US PHS Hospital, Balto, Md.		ADDRESS	
18. 205701 CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute myelogenous leukemia		Months	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from July 6 19 69 to Dec. 30 19 69 , that (1) (we) last saw the deceased alive on Dec. 30 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Gary E. Feldman, M.D.		23B. DATE SIGNED 12/30/69	
23C. PHYSICIAN'S NAME (Type) Gary E. Feldman, SA Surg (R)		23D. ADDRESS US PHS Hospital, Balto, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-2-70	
24C. NAME of CEMETERY or CREMATORY Mt. Comfort Cemetery		24D. LOCATION (City, town, or county) (State) Fairfax County, Virginia	
25A. DATE REC'D BY HEALTH DEPT. JAN 5 1970		25B. NAME of REGISTRAR Everly-Wheatley Funeral Home Alex., Va.	
25C. FUNERAL DIRECTOR ADDRESS		25D. FUNERAL DIRECTOR ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

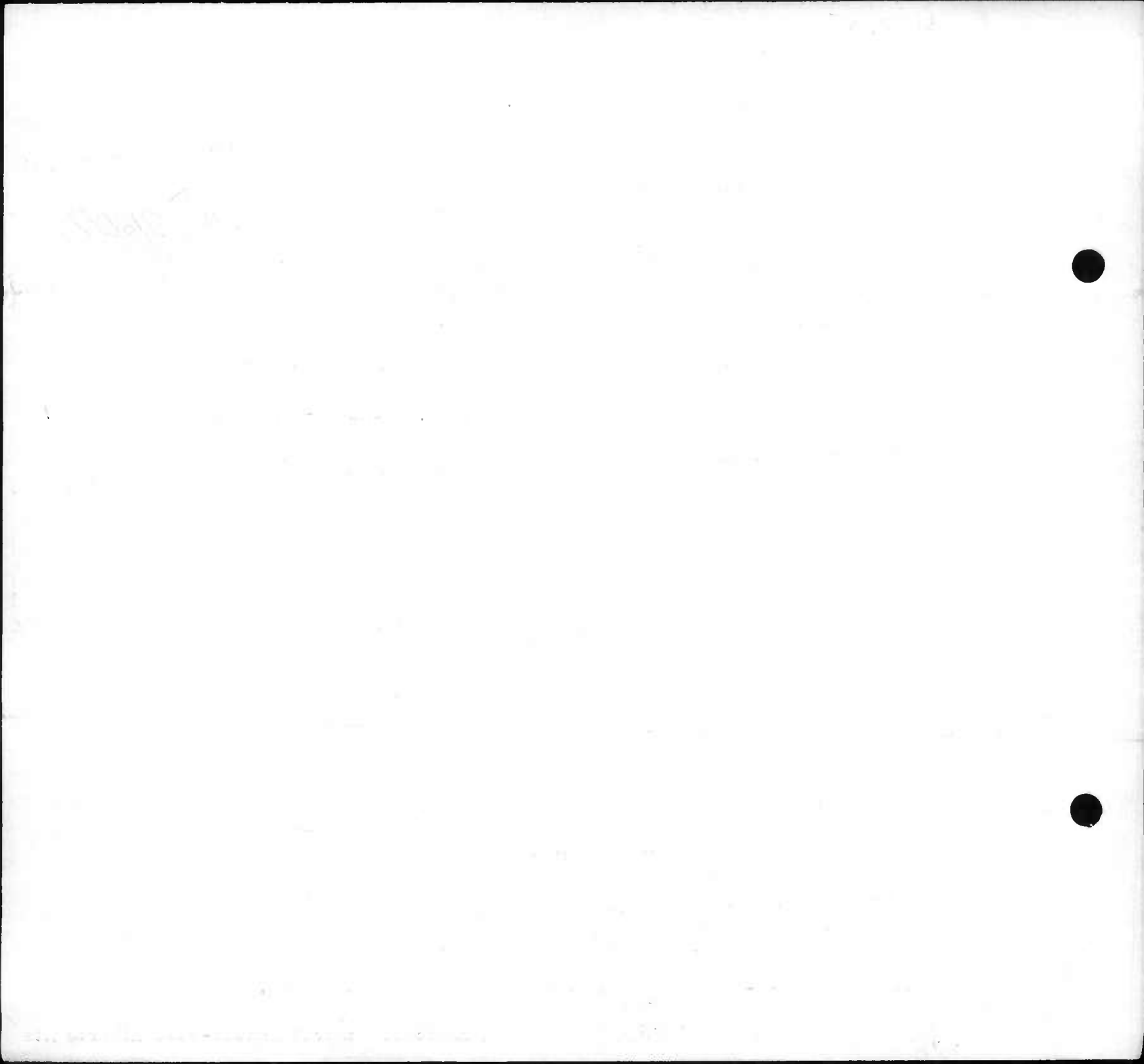
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO.	
X-468		69 13106		69 13106	
CERTIFICATE OF DEATH				BIRTH NO.	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
HELEN T. KELLER			December 31, 1969 3:30 A. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
3405 Mueller St. Baltimore, 21224, Md.			Md.		
C. CITY OR TOWN			D. INSIDE CITY LIMITS?		
Baltimore			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER			3405 Mueller St. # 21224.		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Female	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Nov. 22, 1904	65	Retired
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
House Work			Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?
U.S.A.			13. FATHER'S NAME		
Simon Hruz			14. MOTHER'S MAIDEN NAME		
Mary Sojak			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
No			16. SOCIAL SECURITY NO.		
212-22-7264			17. INFORMANT		
Joseph P. Keller			ADDRESS		
Same			18. CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)			I		
ANTECEDENT CAUSES			(A) IMMEDIATE CAUSE		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			Acute Myocardial infarction		
			DUE TO, OR AS A CONSEQUENCE OF:		
			(B) Congestive heart failure		
			DUE TO, OR AS A CONSEQUENCE OF:		
			(C)		
			II		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
 Artemio Arciaga, Jr.				Jan 2 1970	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Artemio Arciaga, Jr.				3501 Fait Ave. Baltimore, 21224, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		1-3-70.		Holy Redeemer Cemetery	
24D. LOCATION (City, town, or county)		24E. LOCATION (State)		24F. LOCATION (State)	
4430 Belair Rd., Balto., Md.		4430 Belair Rd., Balto., Md.		4430 Belair Rd., Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JAN 5 1970		Artemio Arciaga, Jr.		901 S. Conkling St. Balto., 21224, Md.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-345		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 13107	
BIRTH NO. 69 13107		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Maitland, Horace N.</i>		2. DATE AND HOUR OF DEATH <i>31 Dec 1969 7²⁵ P.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Singer Hospital of Baltimore</i>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>3738 Milford Ave 21207</i>			
5. SEX <i>Female</i>	6. RACE <i>Caucasian</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9/10/95</i>	9. AGE (in years last birthday) <i>74</i>	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Sales Lady</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
13. FATHER'S NAME <i>Charles Neilson</i>		14. MOTHER'S MAIDEN NAME <i>Suzanna Wood</i>		12. CITIZEN OF WHAT COUNTRY <i>USA</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>John C. Maitland - 3738 Milford Avenue #7</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Cerebrovascular accident</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>Undifferentiable of neck primary unknown</i>		19. DATE OF OPERATION <i>2</i>			
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>YES</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from <i>28 Dec</i> 19 <i>69</i> to <i>31 Dec</i> 19 <i>69</i> that (we) last saw the deceased alive on <i>31 Dec</i> 19 <i>69</i> and that (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) view the body after death.					
23A. SIGNATURE <i>Morris Ostroff MD</i>		23B. DATE SIGNED <i>31 Dec 1969</i>		23C. PHYSICIAN'S NAME (Type) <i>Morris Ostroff MD</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1-3-70</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Woodlawn Cemetery</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 5 1970</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Arma Cost</i>	
25D. ADDRESS <i>Arma Cost Funeral Chapel-4600 Liberty Hts</i>					



33-15-46 Body released to family

VS 150-REV. 1/1/68

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

E-522		69 13108		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 13108	
BIRTH NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Edward N. Ensign</u>				December 31, 1969 4 05 P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>31</u> <u>BALTIMORE CITY HOSPITALS</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland 21224</u>				A. STATE <u>Maryland</u> B. COUNTY <u>2608</u>			
				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>1 S. Conkling St. 21224 007</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-7-15</u>	9. AGE (In years last birthday) <u>54</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Elmer Ensign</u>				14. MOTHER'S MAIDEN NAME <u>Minerva Stout</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>BCH-Records</u>		ADDRESS <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland 21224</u>	
18. <u>410.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>myocardial infarct</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>AS LVD</u> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>myocardial infarct</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>AS LVD</u> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>years</u>	
19A. DATE OF OPERATION <u>0</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>12-31-69</u> 19 to <u>12-31</u> 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>12-31</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>John R. Burton</u>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>12-31-69</u>	
23C. PHYSICIAN'S NAME (Type) <u>John R. Burton</u>				23D. ADDRESS <u>BCH- 4940 Eastern Avenue</u> <u>Baltimore, Maryland 21224</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/5/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 5 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. [unclear]</u>		25C. FUNERAL DIRECTOR <u>John A. Moran, Inc.</u>		ADDRESS <u>3000 E. Baltimore St</u>	

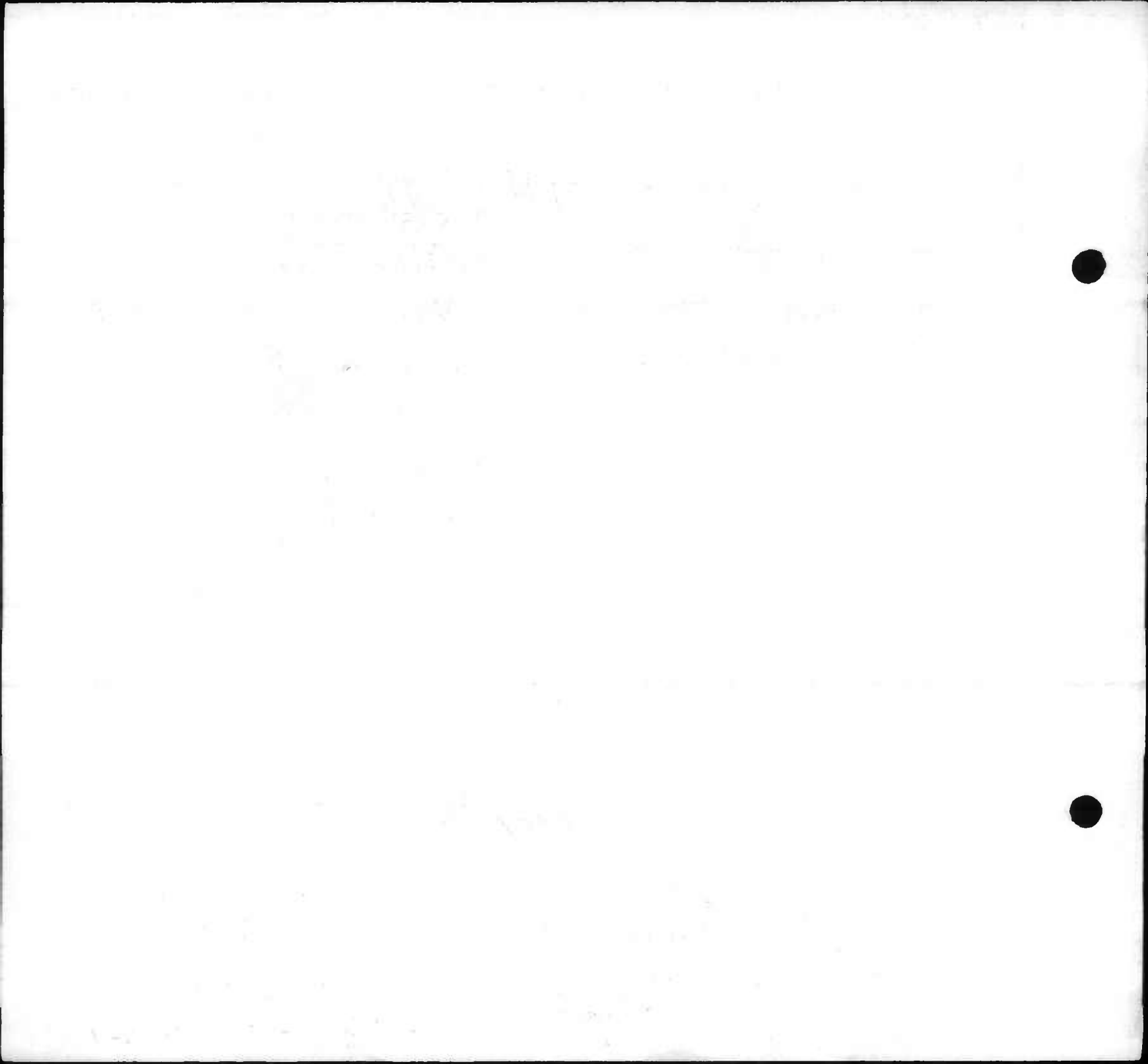
1991-2001

1950-1951 = 1950-1951

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

3-625		69 13109		BALTIMORE CITY HEALTH DEPARTMENT		69 13109	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) GERSTMAN, IRWIN CHARLES				2. DATE AND HOUR OF DEATH 12/30/69 10:15 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) University of Maryland Hospital 38				A. STATE Washington, D.C. V-48			
				C. CITY OR TOWN Washington, D.C.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 725 3rd Street S.W.			
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/19/36	9. AGE (In years last birthday) 33	10. Under 1 Yr. Months	11. Under 24 Hrs. Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant				10B. KIND OF BUSINESS OR INDUSTRY Associates Opticians Inc.		11. BIRTHPLACE (State or foreign country) Va.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME David Gershman				14. MOTHER'S MAIDEN NAME Fannie Feingold			
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT Reba Wright Gershman	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Diabetic Gangrene				CAUSE OF DEATH (A) IMMEDIATE CAUSE Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic Heart Disease (B) Long standing Diabetes DUE TO, OR AS A CONSEQUENCE OF: (C) Previous myocardial infarction APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 12-30-69				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Diabetic Gangrene		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11/21/1969 to 12/30/1969 that (I) (we) last saw the deceased alive on 12/30/1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE John Mathai				23B. DATE SIGNED 12/30/69		23C. PHYSICIAN'S NAME (Type) JOHN MATHAI M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 1-2-70		24C. NAME OF CEMETERY or CREMATORY Hebrew Oakwood Cemetery	
24D. LOCATION Richmond, Virginia				25A. DATE REC'D BY HEALTH DEPT. JAN 5 1970		25B. NAME OF REGISTRAR Reba E. Gershman	
25C. FUNERAL DIRECTOR John C. Miller Inc				25D. ADDRESS 6415 Belair Rd.		25E. ADDRESS -21206	



C-260

69 13110

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO.

69 13110

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Mollie Cowger

2. DATE AND HOUR OF DEATH

Dec 29, 1969 11:00 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTIONIF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATIONBaltimore City Hospital
4940 Eastern Ave., Balto. Md. 212244. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland Baltimore

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐NO ☒

E. STREET AND NUMBER

1622 Capemay Road, Baltimore, Md. 21221

5. SEX

Female

6. RACE

White

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

7-14-08

9. AGE (In years
last birthday)

61

10. Under 1 Yr. 1 Yr. 2 Yrs. 3 Yrs. 4 Yrs. 5 Yrs. 6 Yrs. 7 Yrs. 8 Yrs. 9 Yrs. 10 Yrs. 11 Yrs. 12 Yrs. 13 Yrs. 14 Yrs. 15 Yrs. 16 Yrs. 17 Yrs. 18 Yrs. 19 Yrs. 20 Yrs. 21 Yrs. 22 Yrs. 23 Yrs. 24 Yrs. 25 Yrs. 26 Yrs. 27 Yrs. 28 Yrs. 29 Yrs. 30 Yrs. 31 Yrs. 32 Yrs. 33 Yrs. 34 Yrs. 35 Yrs. 36 Yrs. 37 Yrs. 38 Yrs. 39 Yrs. 40 Yrs. 41 Yrs. 42 Yrs. 43 Yrs. 44 Yrs. 45 Yrs. 46 Yrs. 47 Yrs. 48 Yrs. 49 Yrs. 50 Yrs. 51 Yrs. 52 Yrs. 53 Yrs. 54 Yrs. 55 Yrs. 56 Yrs. 57 Yrs. 58 Yrs. 59 Yrs. 60 Yrs. 61 Yrs. 62 Yrs. 63 Yrs. 64 Yrs. 65 Yrs. 66 Yrs. 67 Yrs. 68 Yrs. 69 Yrs. 70 Yrs. 71 Yrs. 72 Yrs. 73 Yrs. 74 Yrs. 75 Yrs. 76 Yrs. 77 Yrs. 78 Yrs. 79 Yrs. 80 Yrs. 81 Yrs. 82 Yrs. 83 Yrs. 84 Yrs. 85 Yrs. 86 Yrs. 87 Yrs. 88 Yrs. 89 Yrs. 90 Yrs. 91 Yrs. 92 Yrs. 93 Yrs. 94 Yrs. 95 Yrs. 96 Yrs. 97 Yrs. 98 Yrs. 99 Yrs. 100 Yrs.

11. Under 1 Yr. 1 Yr. 2 Yrs. 3 Yrs. 4 Yrs. 5 Yrs. 6 Yrs. 7 Yrs. 8 Yrs. 9 Yrs. 10 Yrs. 11 Yrs. 12 Yrs. 13 Yrs. 14 Yrs. 15 Yrs. 16 Yrs. 17 Yrs. 18 Yrs. 19 Yrs. 20 Yrs. 21 Yrs. 22 Yrs. 23 Yrs. 24 Yrs. 25 Yrs. 26 Yrs. 27 Yrs. 28 Yrs. 29 Yrs. 30 Yrs. 31 Yrs. 32 Yrs. 33 Yrs. 34 Yrs. 35 Yrs. 36 Yrs. 37 Yrs. 38 Yrs. 39 Yrs. 40 Yrs. 41 Yrs. 42 Yrs. 43 Yrs. 44 Yrs. 45 Yrs. 46 Yrs. 47 Yrs. 48 Yrs. 49 Yrs. 50 Yrs. 51 Yrs. 52 Yrs. 53 Yrs. 54 Yrs. 55 Yrs. 56 Yrs. 57 Yrs. 58 Yrs. 59 Yrs. 60 Yrs. 61 Yrs. 62 Yrs. 63 Yrs. 64 Yrs. 65 Yrs. 66 Yrs. 67 Yrs. 68 Yrs. 69 Yrs. 70 Yrs. 71 Yrs. 72 Yrs. 73 Yrs. 74 Yrs. 75 Yrs. 76 Yrs. 77 Yrs. 78 Yrs. 79 Yrs. 80 Yrs. 81 Yrs. 82 Yrs. 83 Yrs. 84 Yrs. 85 Yrs. 86 Yrs. 87 Yrs. 88 Yrs. 89 Yrs. 90 Yrs. 91 Yrs. 92 Yrs. 93 Yrs. 94 Yrs. 95 Yrs. 96 Yrs. 97 Yrs. 98 Yrs. 99 Yrs. 100 Yrs.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

Canning Co.

11. BIRTHPLACE (State or foreign country)

West Virginia

12. CITIZEN OF WHAT COUNTRY?

United States

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

214 20 8739

17. INFORMANT

4940 Eastern Avenue
BCH Records: Baltimore, Maryland 21224

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Cancer of lung

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

4 mos.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

None

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

None

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

YES

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)

None

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

None

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

None

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12/17 to 12/29 1969
that (I) (we) last saw the deceased alive on 12/29 1969 and that (I) (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Hubert W. Gerry MD

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

Dec 29, 1969

23C. PHYSICIAN'S
NAME (Type)

Hubert W. Gerry

DEGREE

23D. ADDRESS

4940 Eastern Ave., Balto. Md. 21224
Baltimore City Hospital24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

1/2/70

24C. NAME OF CEMETERY or CREMATORY

Holly Hill Memorial Gardens

24D. LOCATION

Baltimore Co., Md.

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

JAN 5 1970

25B. NAME OF REGISTRAR

Robert E. [Signature]

25C. FUNERAL DIRECTOR

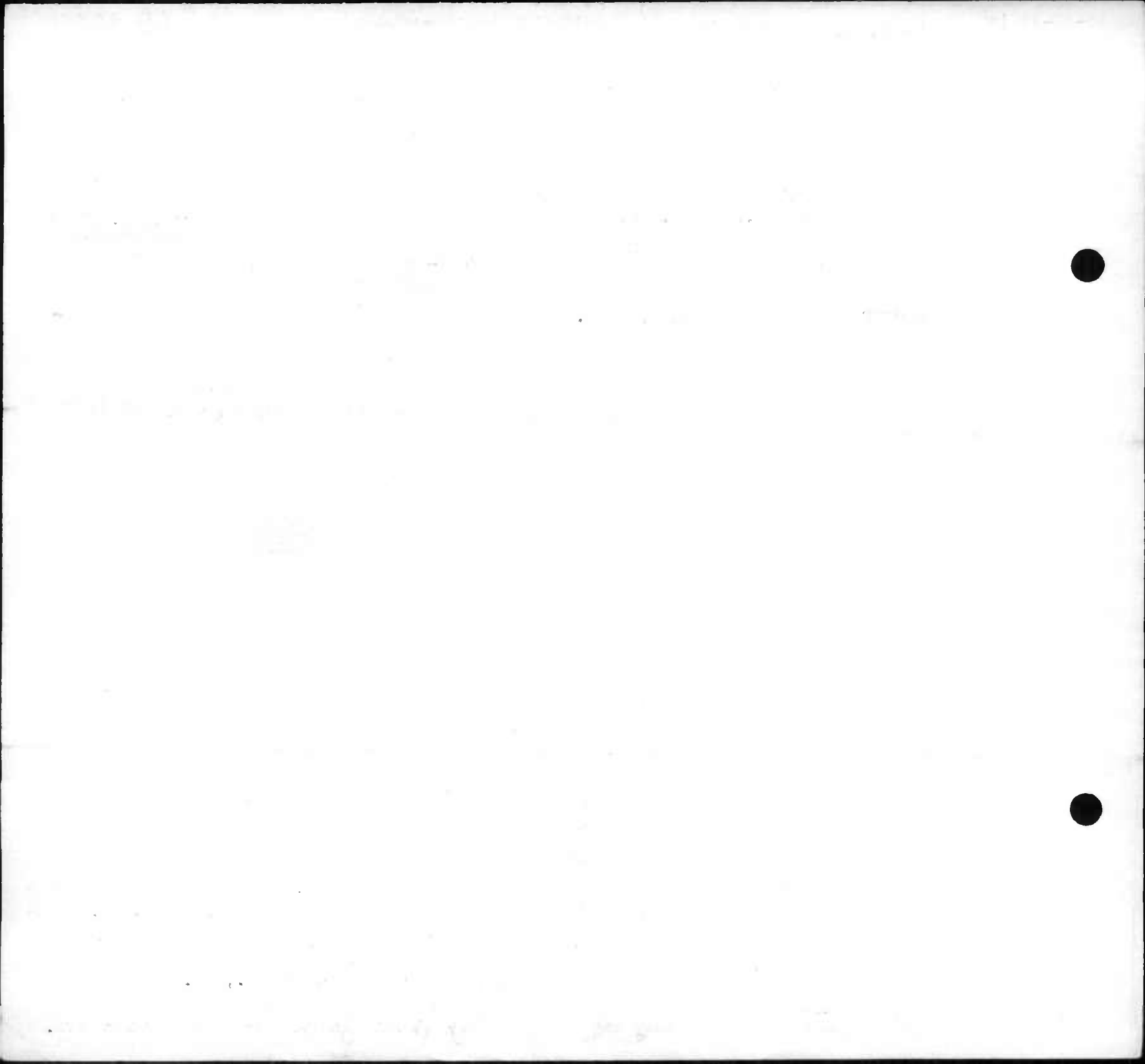
[Signature]

ADDRESS

Brzezinski Funeral Home 1407 Eastern Ave.

FUNERAL DIRECTOR: IMPORTANT

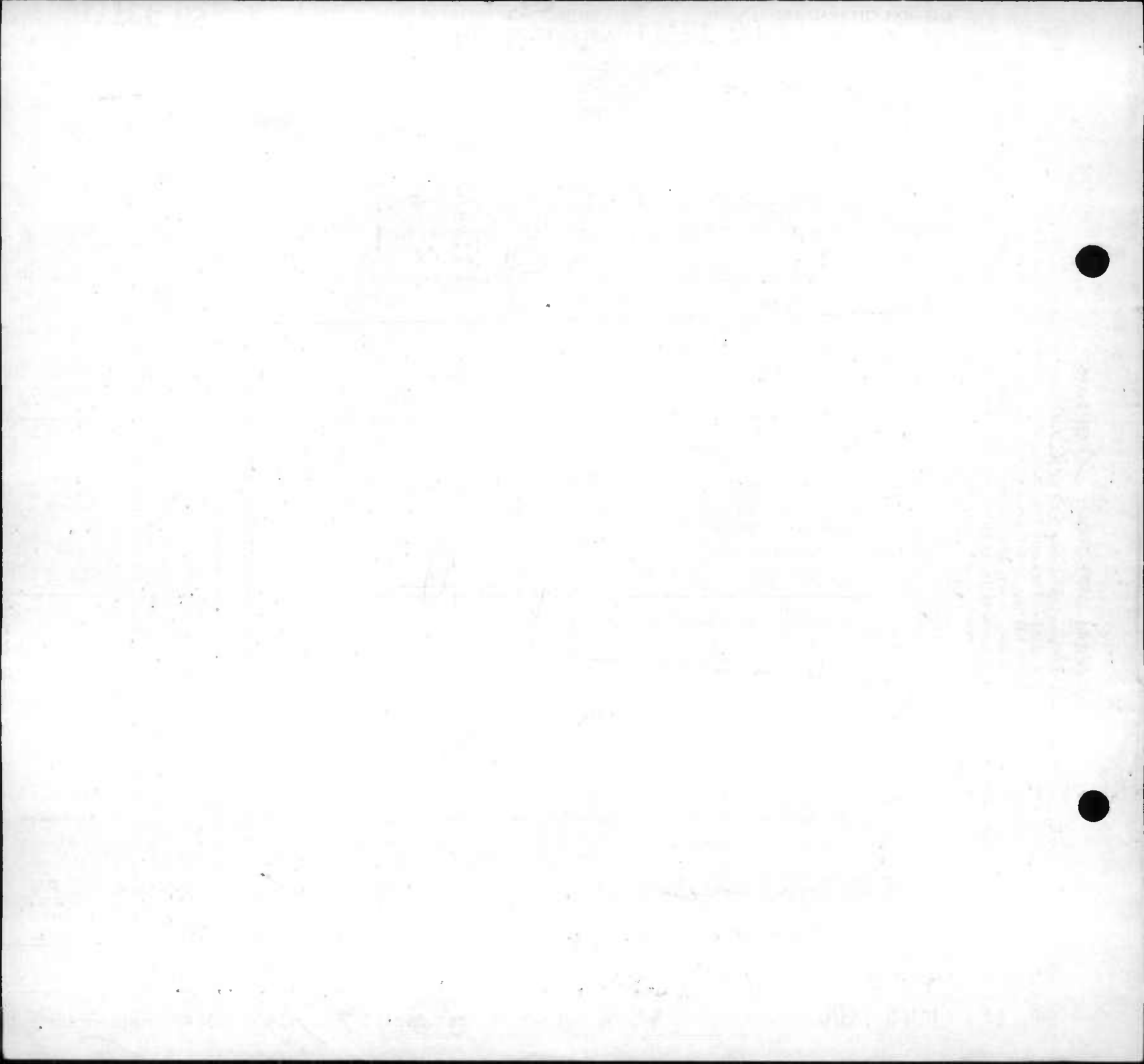
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 13111	
<div style="display: flex; justify-content: space-between;"> B-536 69 13111 </div> <div style="text-align: center; font-weight: bold; font-size: 1.2em;">CERTIFICATE OF DEATH</div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Elizabeth Faust Bender BENDER MRS. ELIZABETH F.		2. DATE AND HOUR OF DEATH 12/29/69 10:55PM M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 35 CHURCH HOME AND HOSPITAL.		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION 35 CHURCH HOME AND HOSPITAL.		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER 427 MAISON ST 21224	
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-28-18	9. AGE (In years last birthday) 51	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Operator		10B. KIND OF BUSINESS OR INDUSTRY Polyseal Corp.		11. BIRTHPLACE (State or foreign country) PA.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME AUGUSTINE FAUST		14. MOTHER'S MAIDEN NAME MARY SAUNDERS.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no at unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 176-18-0728		17. INFORMANT WILLIAM FAUST- 514 S. WOODWARD DR.	
18. 1991 I		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: TERMINAL CARCINOMA.			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) DUE TO, OR AS A CONSEQUENCE OF:					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 10-31-69		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CARCINOMA.		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10-23-69 19 to 12/29/69 19, that (I) (we) last saw the deceased alive on 12/29/69 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Prabir K. Bose M.D.				23B. DATE SIGNED 12-30-69.	
23C. PHYSICIAN'S NAME (Type) PRABIR K. BOSE. M.D.				23D. ADDRESS Church Home & Hospital Baltimore	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/2/70		24C. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore Co., Md.		25A. DATE REC'D BY HEALTH DEPT. JAN 5 1970			
25B. NAME OF REGISTRAR J. E. ...		25C. FUNERAL DIRECTOR Brazdzinski Funeral Home			
ADDRESS 1407 Eastern Ave.					



W-4/6

69 13112

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 13112

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ALVIN J. WOLFORD		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> December 31, 1969 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 3633 Buena Vista Avenue		3. DATE PRONOUNCED DEAD Month Day Year Hour December 31, 1969 11:55 A.M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH Aug. 11, 1923		10. AGE (In years last birthday) 46	
11. BIRTHPLACE (State or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Samuel M. Wolford.		14. MOTHER'S MAIDEN NAME Edna G. Wolford.	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist.		16. KIND OF BUSINESS OR INDUSTRY Ray Electric Co.	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		18. SOCIAL SECURITY NO. 193-14-5082	
19. CAUSE OF DEATH E955X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) (Partial) Yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 3633 Buena Vista Avenue 1348		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 12-31-69 11:30 A.M.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Shot self	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate EXAMINER'S NAME (Type) Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED January 1, 1970	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-5-70	
24C. NAME OF CEMETERY or CREMATORY Grandview.		24D. LOCATION (City, town, or county) (State) Altoona Pa.	
25A. DATE REC'D BY HEALTH DEPT. JAN 5 1970		25B. NAME OF REGISTRAR Robert E. Fisher	
25C. FUNERAL DIRECTOR Paul E. Chonoweth Jr.		ADDRESS 3615 Chestnut Ave.	

THOMAS J. WILSON

UNITED STATES DEPARTMENT OF JUSTICE

1915

1915

APR. 11, 1915

RECEIVED

U.S. DEPT. OF JUSTICE

WASHINGTON, D.C.

U.S. DEPT. OF JUSTICE

1915

U.S. DEPT. OF JUSTICE

U.S. DEPT. OF JUSTICE

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U.S. DEPT. OF JUSTICE

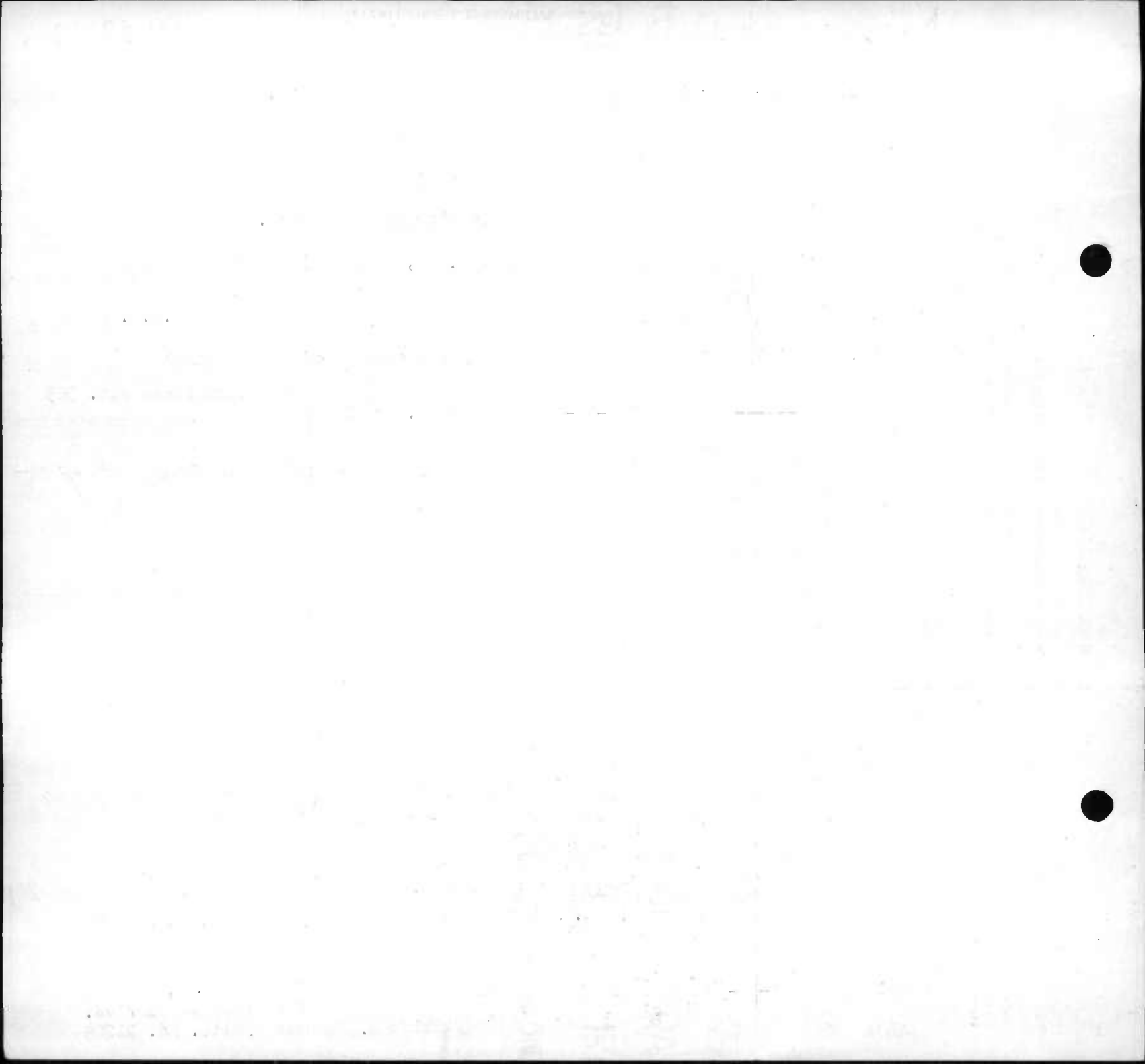
U.S. DEPT. OF JUSTICE

U.S. DEPT. OF JUSTICE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>69 13113</u>	
J-245 69 13113				CERTIFICATE OF DEATH	
BIRTH NO. <u>245</u>		1. NAME OF DECEASED (Type or Print) <u>Carol Leigh Joslin</u>			
2. DATE AND HOUR OF DEATH <u>December 29, 1969</u> <u>9:00</u> A.M.		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>00 15 Charles Plaza</u>			
4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>401</u>		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX <u>Female</u> 6. RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 24, 1935</u> 9. AGE (In years last birthday) <u>34</u>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Leigh Carlisle Sanders</u>			
14. MOTHER'S MAIDEN NAME <u>Margaret Louise Lushgaugh</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>216-32-2519</u>		17. INFORMANT <u>Harry M. Joslin</u> ADDRESS <u>15 Charles Plaza Apt. 503</u>			
18. <u>192.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Oligodendroglioma 6 years</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>31 October 1969</u> to <u>29 December 69</u> , that (I) (we) last saw the deceased alive on <u>19 December 19 69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (and) (did not) view the body after death.					
23A. SIGNATURE <u>James M. Sowa M.D.</u> DEGREE				23B. DATE SIGNED <u>30 December 1969</u>	
23C. PHYSICIAN'S NAME (Type) <u>James M. Sowa, M.D.</u>		23D. ADDRESS <u>3925 Beech Ave. Balto. Md. 21211</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12-31-69</u>		24C. NAME OF CEMETERY or CREMATORY <u>Druid Ridge Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore County, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 5 1970</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>William E. Johnson</u> ADDRESS <u>8521 Loch Raven Blvd. Balto. Md. 21204</u>			



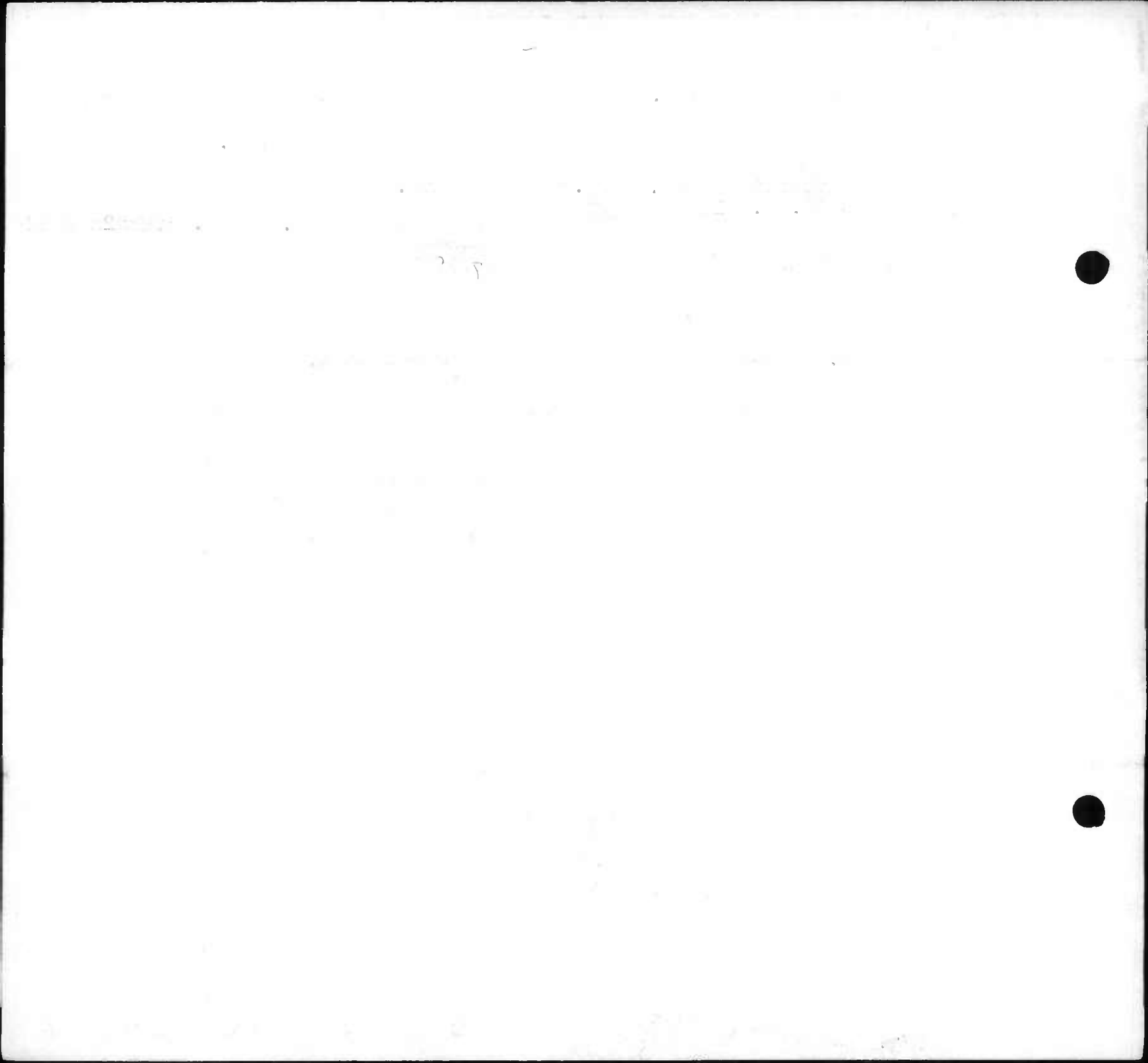
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				69 13114	
H-635 69 13114				REG/NO.	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Siotha Haldine		12/30/69 9 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
628 JUAN BALTON AVE.				MD. 901	
C. CITY OR TOWN				D. INSIDE CITY LIMITS?	
BALTIMORE				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER					
628 JUAN BALTON AVE					
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
F	W		12/31/1899	69	NONE
11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
TENN.					
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Fleming Lovett			Callie Hensley		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
No					Family - Same
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
I 412-1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:				arteriosclerotic heart disease	
(B) DUE TO, OR AS A CONSEQUENCE OF:				Hypertension	
(C) _____					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from June 15 1954 to 12/30 1969, that (I) (we) last saw the deceased alive on 12/25 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Dr. Salm Rubin MD				1/1/70	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
				3513 Sequoia Ave. Baltimore, Md. 21215	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
		1/1/70		GLENN HUGHES	
24D. LOCATION (City, town, or county) (State)		24E. FUNERAL DIRECTOR ADDRESS			
BALTIMORE MD		237 TATAPUSCO AVE			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JAN 5 1970		Robert E. Rubin		237 TATAPUSCO AVE	

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-640		69 13115		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 69 13115			
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <u>Carroll, Paul V.</u>					
2. DATE AND HOUR OF DEATH <u>12/29/69</u> <u>3-50PM</u> M.									
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Balto.</u> <u>2531</u>					
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>38 University of Md. Hosp. Balto. Md. 21201</u>				C. CITY OR TOWN <u>Balto.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
				E. STREET AND NUMBER <u>5159 Stafford Rd. Balto. Md. 21229</u>					
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/19/10</u>	9. AGE (In years last birthday) <u>59</u>	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>FURNITURE</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>James P. Carroll</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Kenny</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES</u> <u>W. W. II</u>		16. SOCIAL SECURITY NO. <u>217-10-7244</u>		17. INFORMANT <u>Patient's Chart</u>		ADDRESS			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Squamous cell Ca. of floor of mouth & metastasis to lungs & bones</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
								(B) DUE TO, OR AS A CONSEQUENCE OF:	
								(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>Dec. 28</u> 19 <u>69</u> to <u>Dec. 29</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>Dec. 29</u> 19 <u>69</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>J. A. Kang, M.D.</u> DEGREE				23B. DATE SIGNED <u>12/29/69</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			
23C. PHYSICIAN'S NAME (Type) <u>J. S. KANG</u> DEGREE				23D. ADDRESS <u>U.S. Maryland Hosp.</u>					
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-2-70</u>		24C. NAME of CEMETERY or CREMATORY <u>Landon Park Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore</u> <u>MD</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 5 1970</u>				25B. NAME of REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Edgar C. Wroughton</u> ADDRESS <u>W. Catonsville, Md.</u>			



69 13116

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 13116

BIRTH NO. 69-180281. NAME OF DECEASED
(Type or Print) Michelle
TINA BURNS2. DATE OF DEATH Known ☐ Month Day Year Hour
Estimated ☐ M.4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
UNION MEMORIAL HOSPITAL (DOA)3. DATE PRONOUNCED DEAD Month Day Year Hour
December 31, 1969 9:35 A. M.5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Maryland B. COUNTY 9056. SEX
Female7. RACE
White8. MARRIED ☐ NEVER MARRIED ☒
WIDOWED ☐ DIVORCED ☐C. CITY OR TOWN
BaltimoreD. INSIDE CITY LIMITS?
YES ☒ NO ☐9. DATE OF BIRTH
9/28/69

10. AGE (In years last birthday)

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.
3 1 1 1E. STREET AND NUMBER
809 Gorsuch Avenue11. BIRTHPLACE (State or foreign country)
Md.12. CITIZEN OF WHAT COUNTRY?
U.S.A.13. FATHER'S NAME
James Burns14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
none

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME
Bonny Klitenic16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
no17. SOCIAL SECURITY NO.
none18. INFORMANT ADDRESS
James Burns same19. 795 X 1

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

Sudden death in infancy

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)
yes22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)

22E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL SIGNATURE
Ronald N. Kornblum
EXAMINER'S NAME (Type)Ronald N. Kornblum, M.D.CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/31/6924A. BURIAL CREMATION, REMOVAL (Specify)
Burial24B. DATE
1/2/7024C. NAME OF CEMETERY or CREMATORY
Holy Redeemer Cem.24D. LOCATION (City, town, or county) (State)
Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

JAN 5 1970Robert J. Taylor, M.D.Robert J. Taylor, M.D.Leonard J. Buck Inc. Balto. Md.

100-100000

UNITED STATES DEPARTMENT OF JUSTICE

Washington

TO THE HONORABLE ATTORNEY GENERAL
FROM THE DIRECTOR, FEDERAL BUREAU OF INVESTIGATION

RE: [Illegible]

DATE: [Illegible]

TO: [Illegible]

FROM: [Illegible]

SUBJECT: [Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

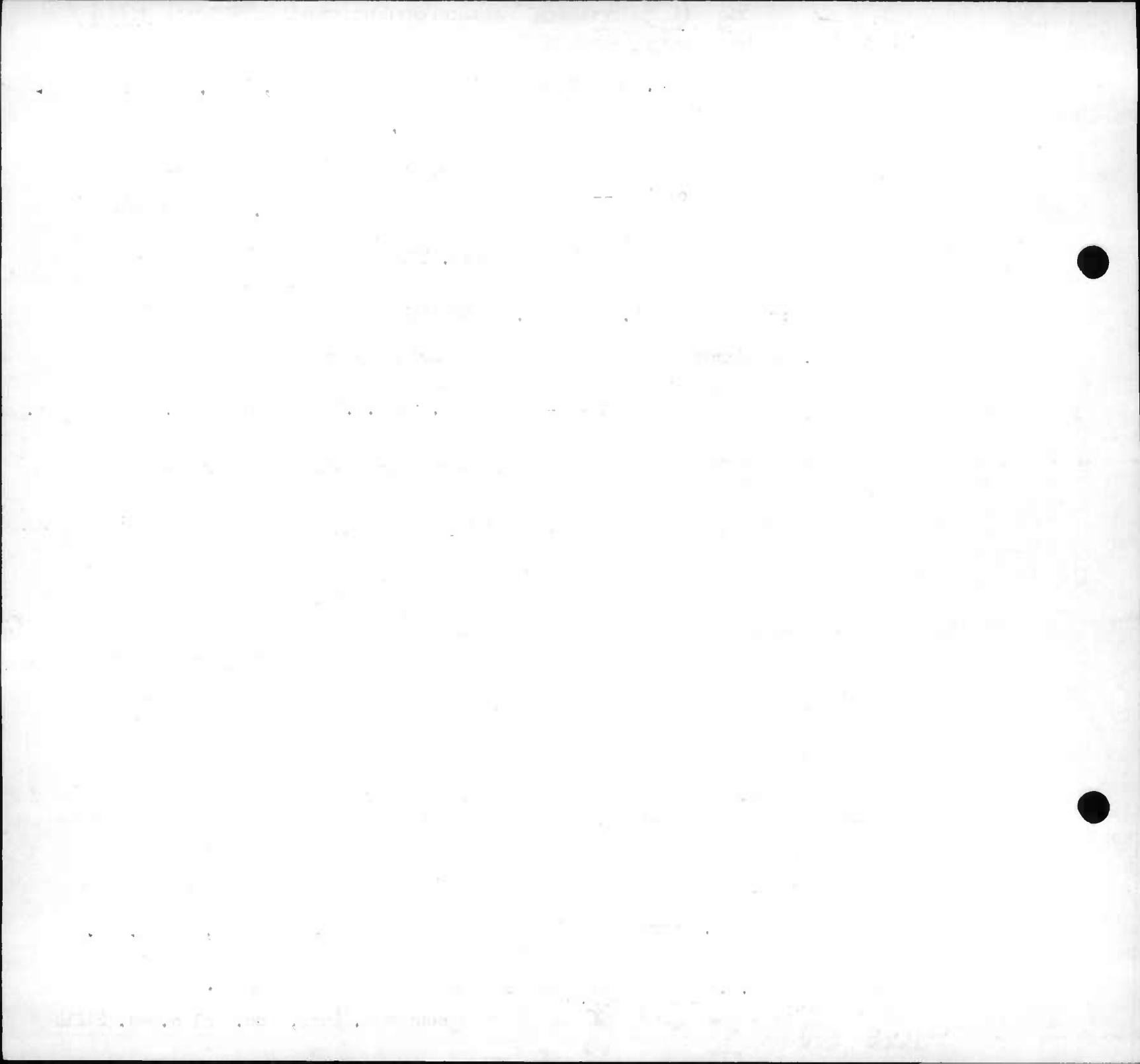
[Illegible]

[Illegible]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

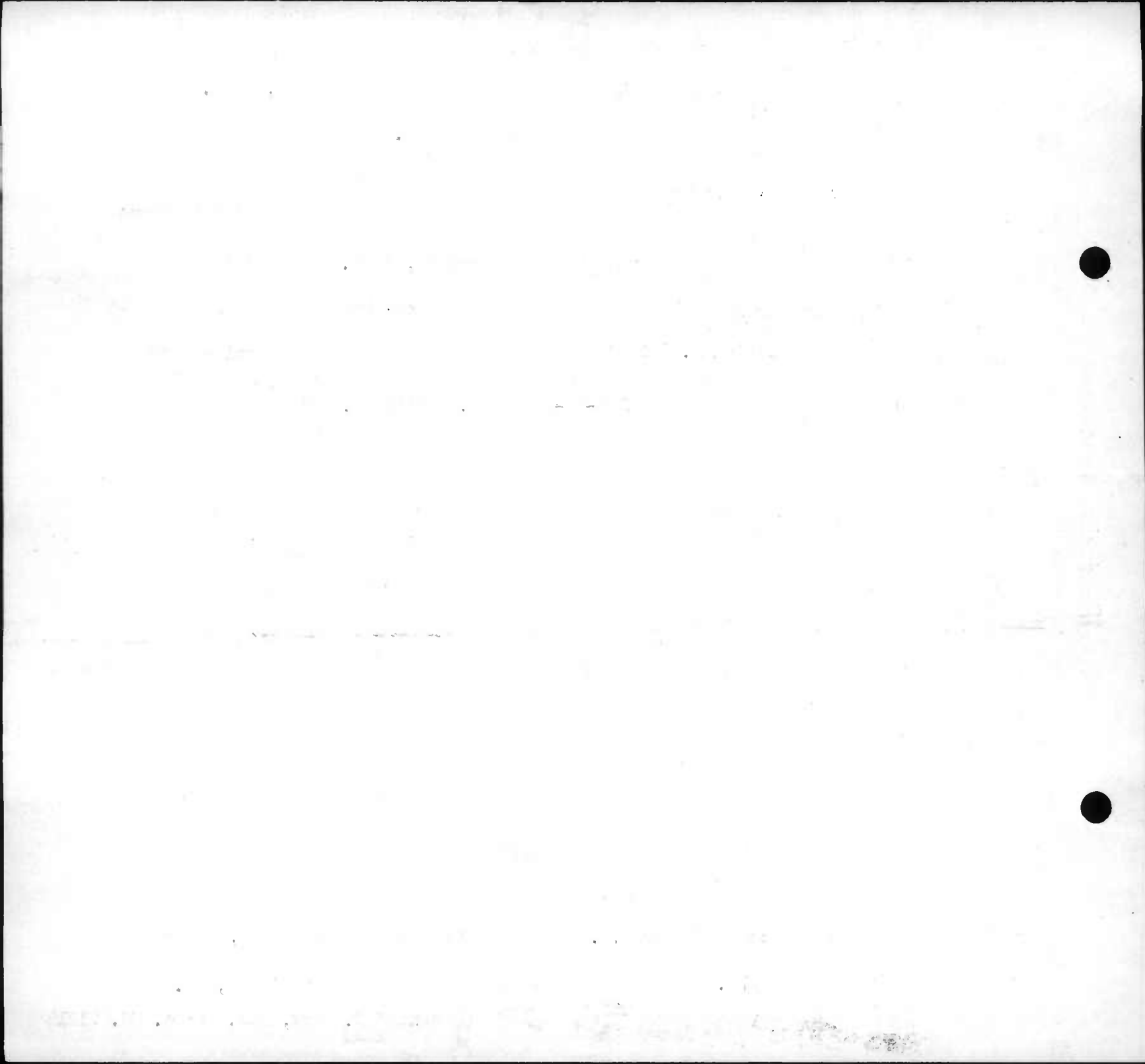
BALTIMORE CITY HEALTH DEPARTMENT <div style="display: flex; justify-content: space-between;"> V-565 69 13117 CERTIFICATE OF DEATH </div>		REG. NO. 69 13117	
BIRTH NO. 1 1. NAME OF DECEASED (Type or Print) BENJAMIN F. VAN HORNE		2. DATE AND HOUR OF DEATH <div style="display: flex;"> <div>December 31, 1969.</div> <div>4:45 A.M.</div> </div>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <div style="font-size: 1.2em;">Johns Hopkins Hospital--DOA</div>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 701 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 818 N. Streeper Street	
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 23, 1901
9. AGE (In years last birthday) 68		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired Glen L. Martin Co.		10B. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Benjamin F. Van Horne		14. MOTHER'S MAIDEN NAME Bertha Green	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 216-07-6496A	
17. INFORMANT Mrs. Benj. F. Van Horne		ADDRESS 818 N. Streeper St.	
18. 433.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CEREBRAL THROMBOSIS 12 HRS. (B) CEREBRAL ARTERIOSCLEROSIS 10 YEARS. (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). HYPOPARATHYROIDISM 3 YRS.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from JULY 15, 1968 to DEC. 30, 1969 , that (I) (we) last saw the deceased alive on 12/30 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Albert C. Herrmann, M.D.		23B. DATE SIGNED 1/1/70	
23C. PHYSICIAN'S NAME (Type) Albert C. Herrmann MD		23D. ADDRESS 5525 Belair Road, Balto. Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE Jan. 3, 1970	
24C. NAME OF CEMETERY or CREMATORY Baltimore Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 5 1970		25B. NAME OF REGISTRAR Robert E. Fisher	
25C. FUNERAL DIRECTOR Leonard J. Buck, Inc.		ADDRESS Balto. Md. 21214	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

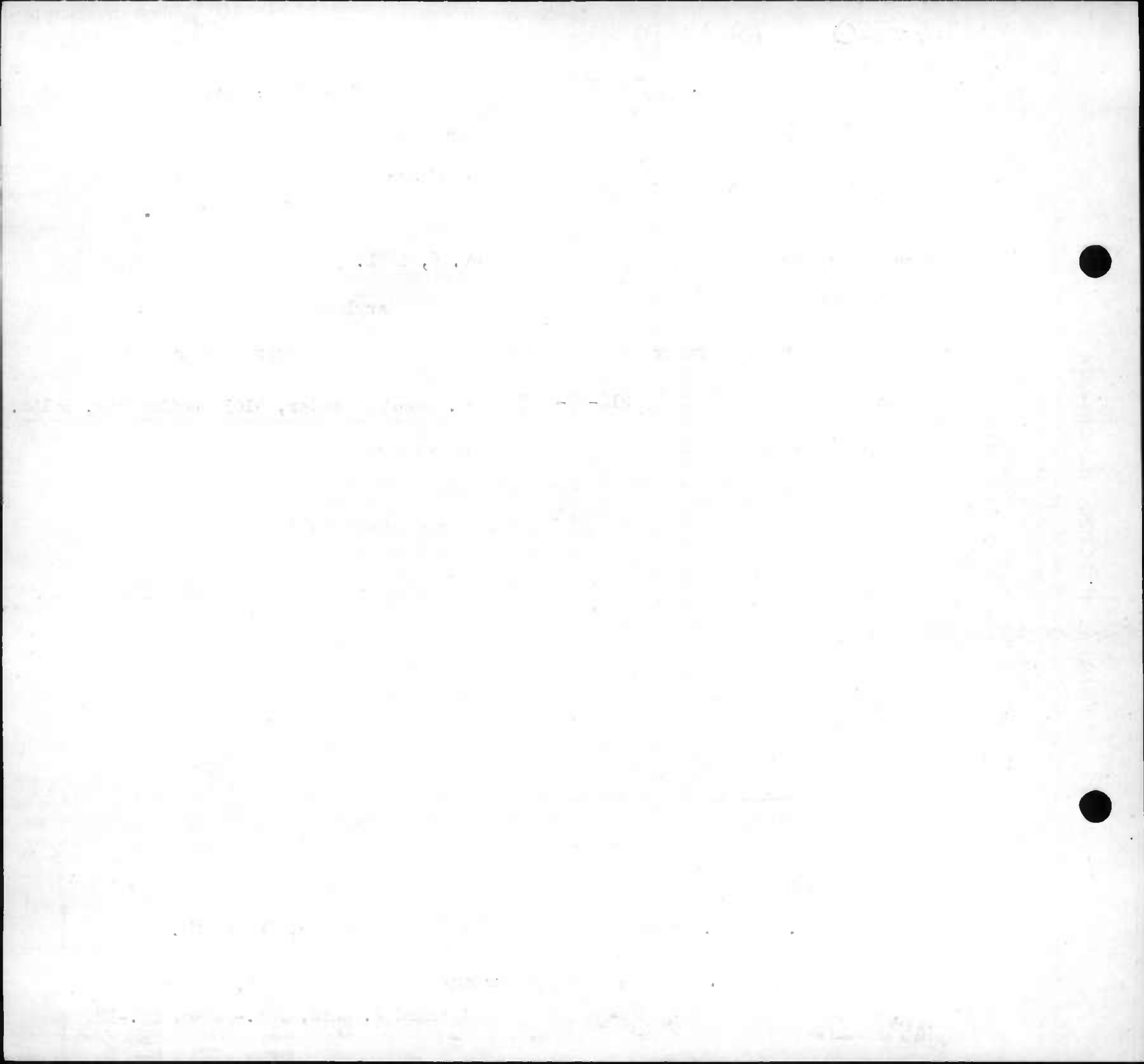
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 13118	
M-624 69 13118		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
MARGARET MARKLE		December 31, 1969. 6 P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 90 Gould Convalesarium		A. STATE		B. COUNTY	
		Md.		2735	
C. CITY OR TOWN		D. INSIDE CITY LIMITS?			
Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER		3224 Orlando Avenue			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. CITIZEN OF WHAT COUNTRY?
Female	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	March 16, 1886.	83	USA
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Retired Seamstress				Maryland	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
William A. Smith			Louise Fink		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		101-18-5117A		Mr. William A. Smith (Same)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		2 mos	
		(B) DUE TO, OR AS A CONSEQUENCE OF:		10 years?	
		(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from Nov 8 1969 to Dec 31 1969 , that (I) (we) last saw the deceased alive on Dec 27 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Frederick J. Vollmer M.D.				Jan 2, 1970	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Frederick J Vollmer M.D.				6100 York Rd Baltimore, Maryland	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		1/5/70.		Parkwood Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JAN 5 1970		Robert A. Taylor, M.D.		Leonard J. Ruck, Inc. Balto. Md. 21214	



FUNERAL DIRECTOR: IMPORTANT

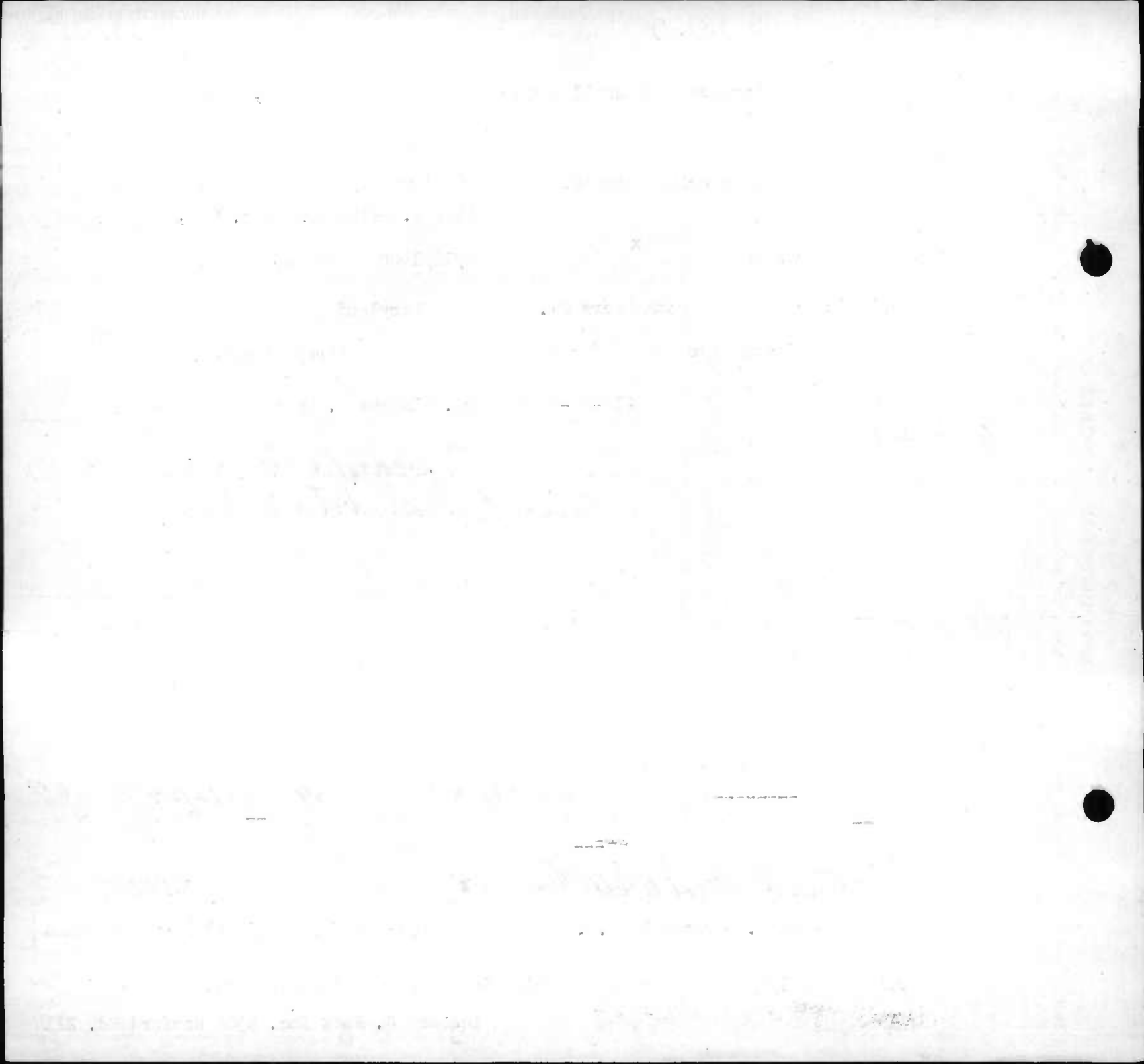
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 13119	
M-520		69 13119		CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		ANNA A. MINNICK		December 31, 1969 4 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE Maryland		
HOUSE IN THE PINES BELAIRE			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 4103 Woodlea Ave.		
5. SEX female	6. RACE caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 5, 1881.	9. AGE (In years last birthday) 88	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Adam Graber		14. MOTHER'S MAIDEN NAME Anna Hemler		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-07-0193B		17. INFORMANT Mrs. Dorothy Feiler, 4103 Woodlea Ave, Balto.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) 440.9 I BRONCHOPNEUMONIA			CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: GENERALIZED ARTERIOCLEROSIS		20 years
			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			(C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 2-4 19 69 to 12-31 1969, that (I) (we) last saw the deceased alive on 12-10 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Adam G. Swiss				23B. DATE SIGNED 12-31-69	
23C. PHYSICIAN'S NAME (Type) Dr. Adam G. Swiss				23D. ADDRESS 6232 Belair Road, Balto, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 1/3/70.		24C. NAME OF CEMETERY OR CREMATORY Rock Spring Cemetery	
				24D. LOCATION (City, town, or county) (State) Forest Hill, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 5 1970		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Leonard J. Buck, Inc.-Balto, Md.-14	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

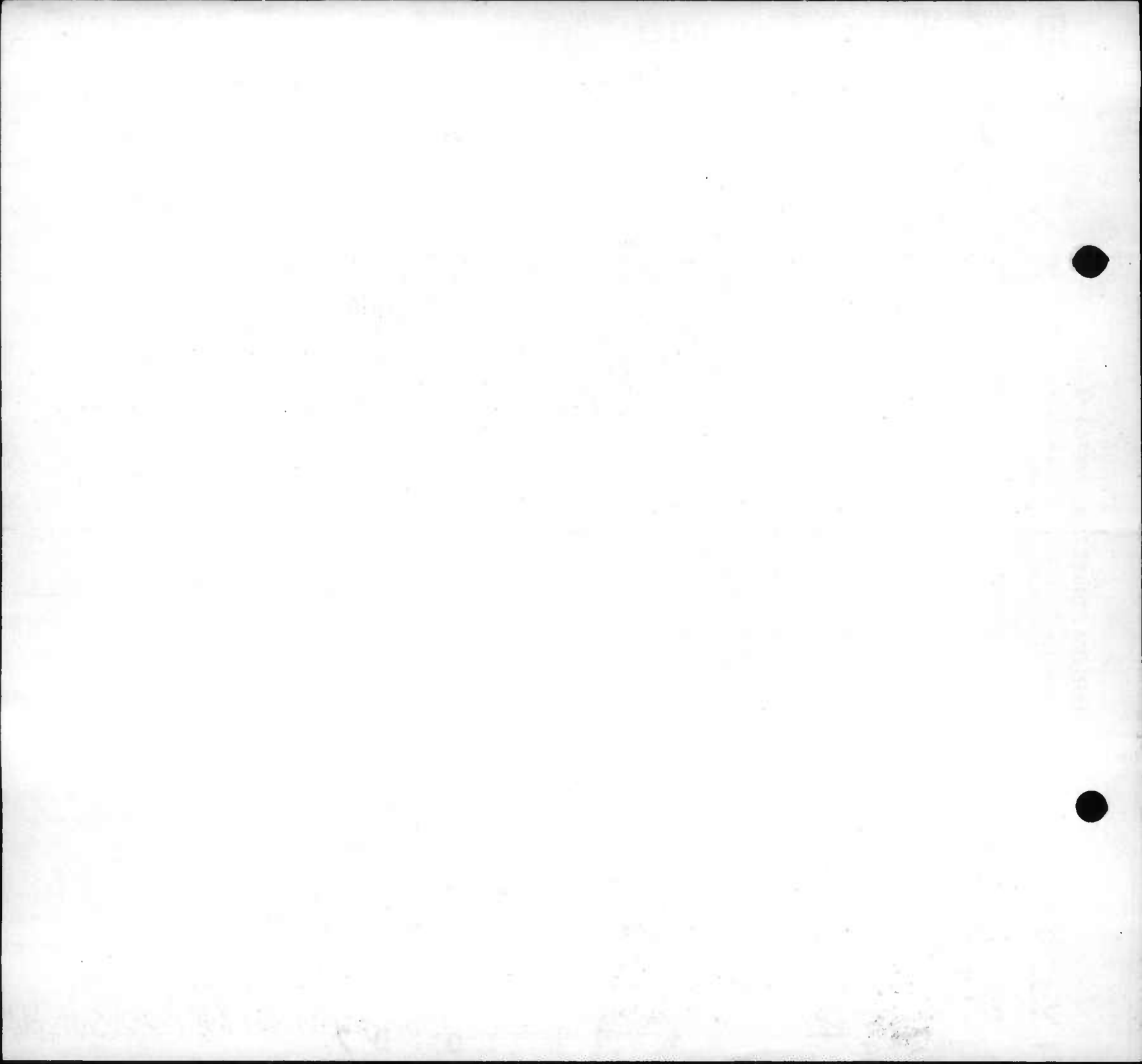
17-200 69 13120		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 13120	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Clarence Mitchell Mays			
2. DATE AND HOUR OF DEATH December 29, 1969 <i>5:10 PM</i>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Union Memorial Hospital			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore		5. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
6. STREET AND NUMBER 1102 E. Belvedere Apt. B		7. FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hospital			
8. SEX Male	9. RACE Caucasian	10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	11. DATE OF BIRTH 9/12/1900	12. AGE (In years last birthday) 69	13. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		15. KIND OF BUSINESS OR INDUSTRY John Deere Co.		16. BIRTHPLACE (State or foreign country) Maryland	
17. CITIZEN OF WHAT COUNTRY? USA		18. FATHER'S NAME Albert Mays		19. MOTHER'S MAIDEN NAME Sarah Alice Jones	
20. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		21. SOCIAL SECURITY NO. 218-05-9647		22. INFORMANT Mrs. Blanche M. Mays	
23. ADDRESS Same		24. CAUSE OF DEATH I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction Instantly Severe Coronary Arteriosclerosis 10 years. II. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Severe Coronary Arteriosclerosis 10 years.			
25. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		26. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 years.			
27. 19A. DATE OF OPERATION		28. 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		29. 20A. AUTOPSY? (Yes or No) No	
30. 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		31. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		32. 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
33. 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		34. 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		35. 21F. HOW DID INJURY OCCUR?	
36. 22. I certify that (I) (the hospital) attended the deceased from 7/31 19 54 to 12/29 19 69 , that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
37. 23A. SIGNATURE <i>John H. Hirschfeld M.D.</i>		38. 23B. DATE SIGNED 12/30/69		39. 23C. PHYSICIAN'S NAME (Type) John H. Hirschfeld M.D.	
40. 23D. ADDRESS 6919 Harford Road Baltimore Maryland		41. 24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
42. 24B. DATE 1/2/70		43. 24C. NAME OF CEMETERY OF CREMATORY Gardens of Faith Cemetery		44. 24D. LOCATION (City, town, or county) (State) Baltimore Maryland	
45. 25A. DATE REC'D BY HEALTH DEPT. JAN 5 1970		46. 25B. NAME OF REGISTRAR Robert E. Taylor		47. 25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. 5305 Harford Rd. 2214	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

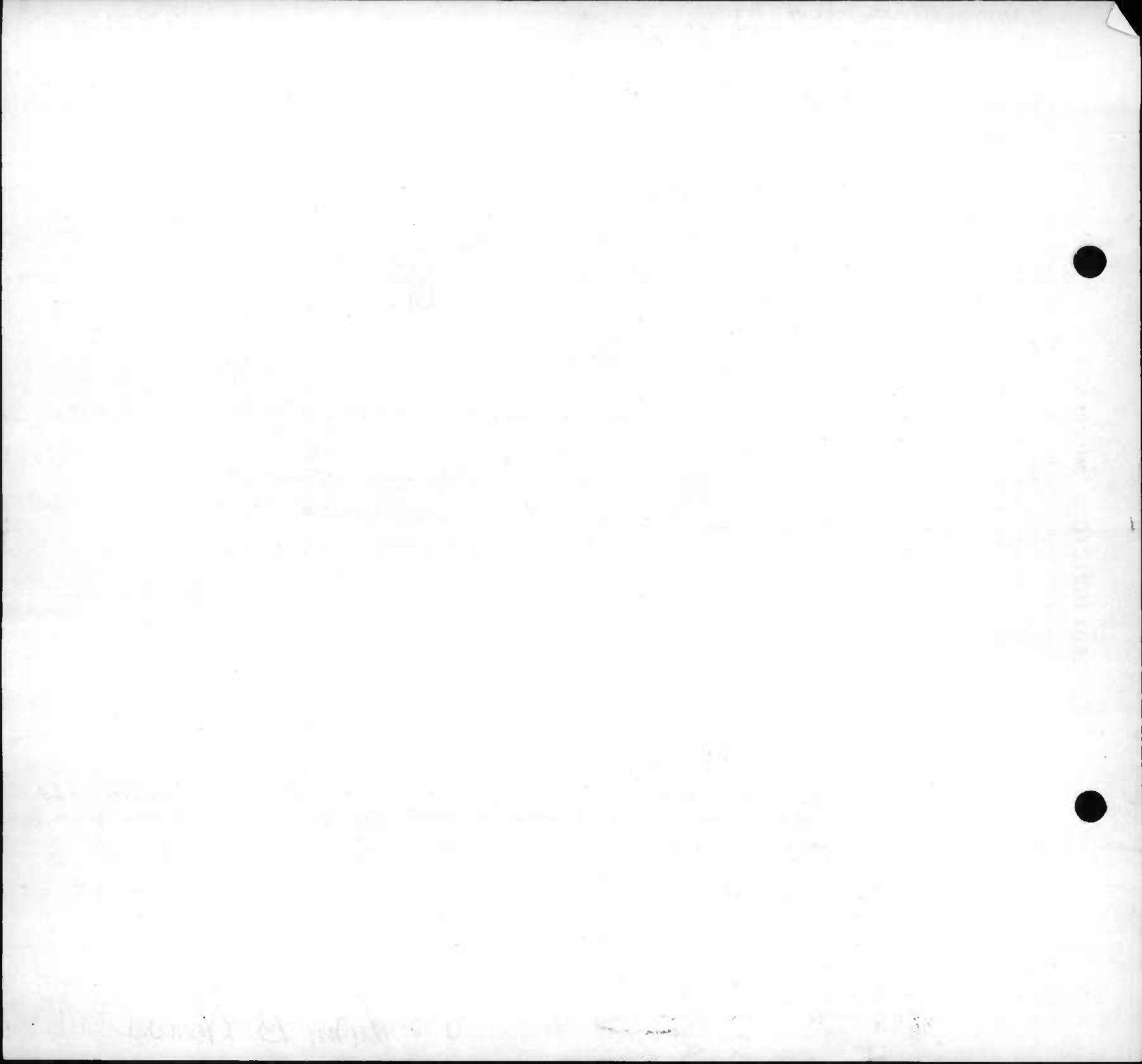
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 13121	
J-612 69 13121				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Lorna M. Jarvis		2. DATE AND HOUR OF DEATH December 28 1969 6:50 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 1118 W. 38th Street			A. STATE Maryland B. COUNTY 1307		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER 1118 W. 38th Street					
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 16 Aug 1916	9. AGE (In years lost birthday) 53	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME George R. Perry			14. MOTHER'S MAIDEN NAME Mary Miller		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-56-5264	17. INFORMANT John G. Jarvis		ADDRESS same
18. 518 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Bronchiectasis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 25 years			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 to 19 , that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Sheldon Goldzeier				23B. DATE SIGNED 12/31/69	
23C. PHYSICIAN'S NAME (Type) Sheldon Goldzeier MD				23D. ADDRESS 848 W 36th	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 31 Dec '69		24C. NAME OF CEMETERY or CREMATORY Lorraine Park Cem.	
24D. LOCATION (City, town, or county) (State) Woodlawn, Md.					
25A. DATE REC'D BY HEALTH DEPT. JAN 5 1970		25B. NAME OF REGISTRAR Robert E. Saylor		25C. FUNERAL DIRECTOR Burgess Funeral Home	
				ADDRESS Balto, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-140		69 13122		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 13122	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Hollis P. Duvall		2. DATE AND HOUR OF DEATH December 28 1969 3 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 The Wesley Home				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2755 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2211 W Rogers Ave 21209			
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7 Nov 1878	9. AGE in years (lost birth day) 91	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas P. Buckingham				14. MOTHER'S MAIDEN NAME Louisa Zepp			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-10-8176A		17. INFORMANT Wesley Home		ADDRESS Same	
18. 412.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hypertensive arteriosclerosis cardiovascular disease (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 30 May 1965 to 28 December 1969 , that (I) (we) lost saw the deceased alive on 23 December 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE John W. Barnaby				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 31 Dec 69	
23C. PHYSICIAN'S NAME (Type) John W. Barnaby				23D. ADDRESS 1652 E Belvedere Ave.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 31 Dec '69		24C. NAME OF CEMETERY OR CREMATORY Oak Grove Cem.		24D. LOCATION (City, town, or county) (State) Glenwood, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 5 1970		25B. NAME OF REGISTRAR 0001		25C. FUNERAL DIRECTOR 0001		ADDRESS 0001	

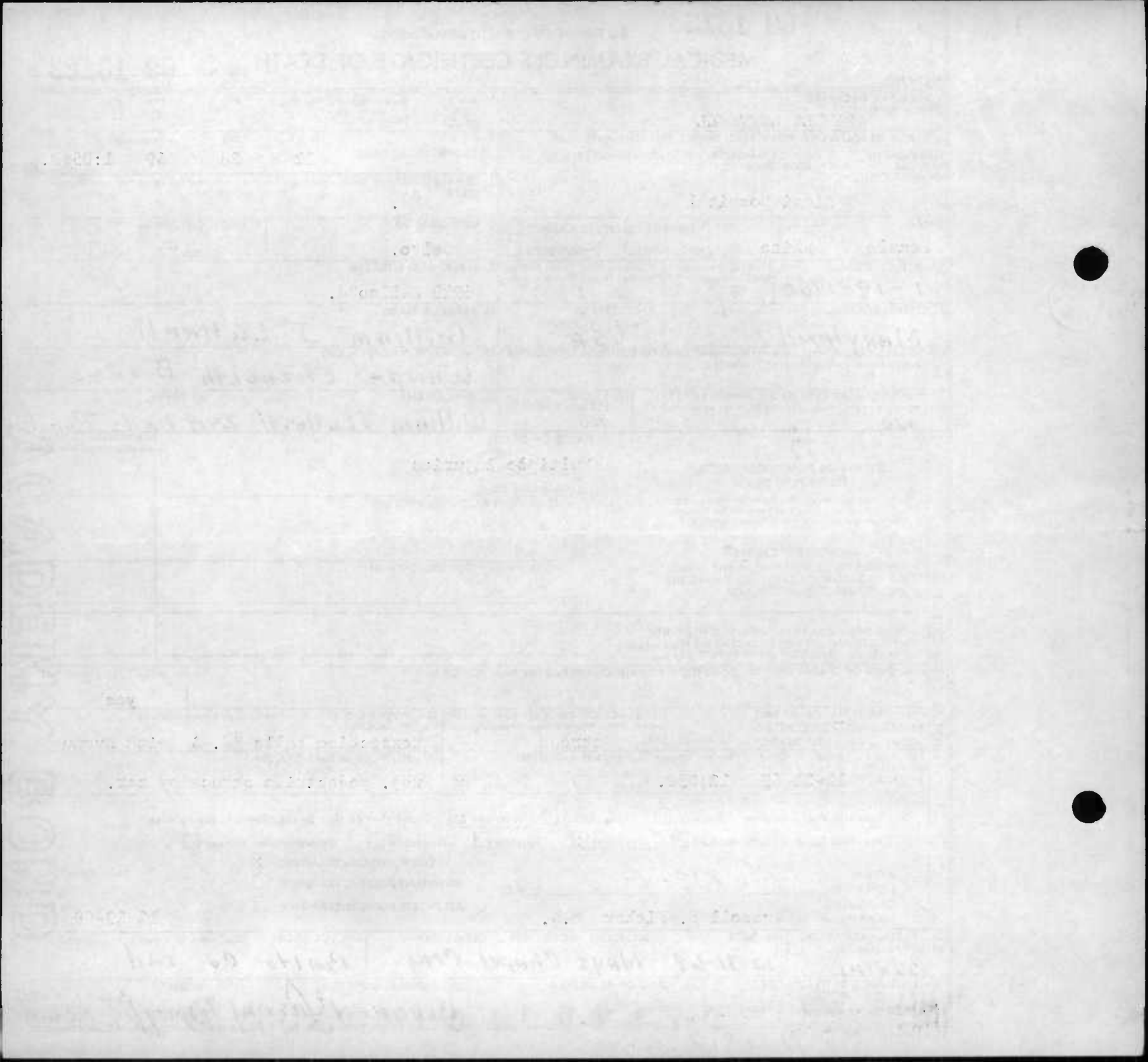


MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 13123

BIRTH NO.

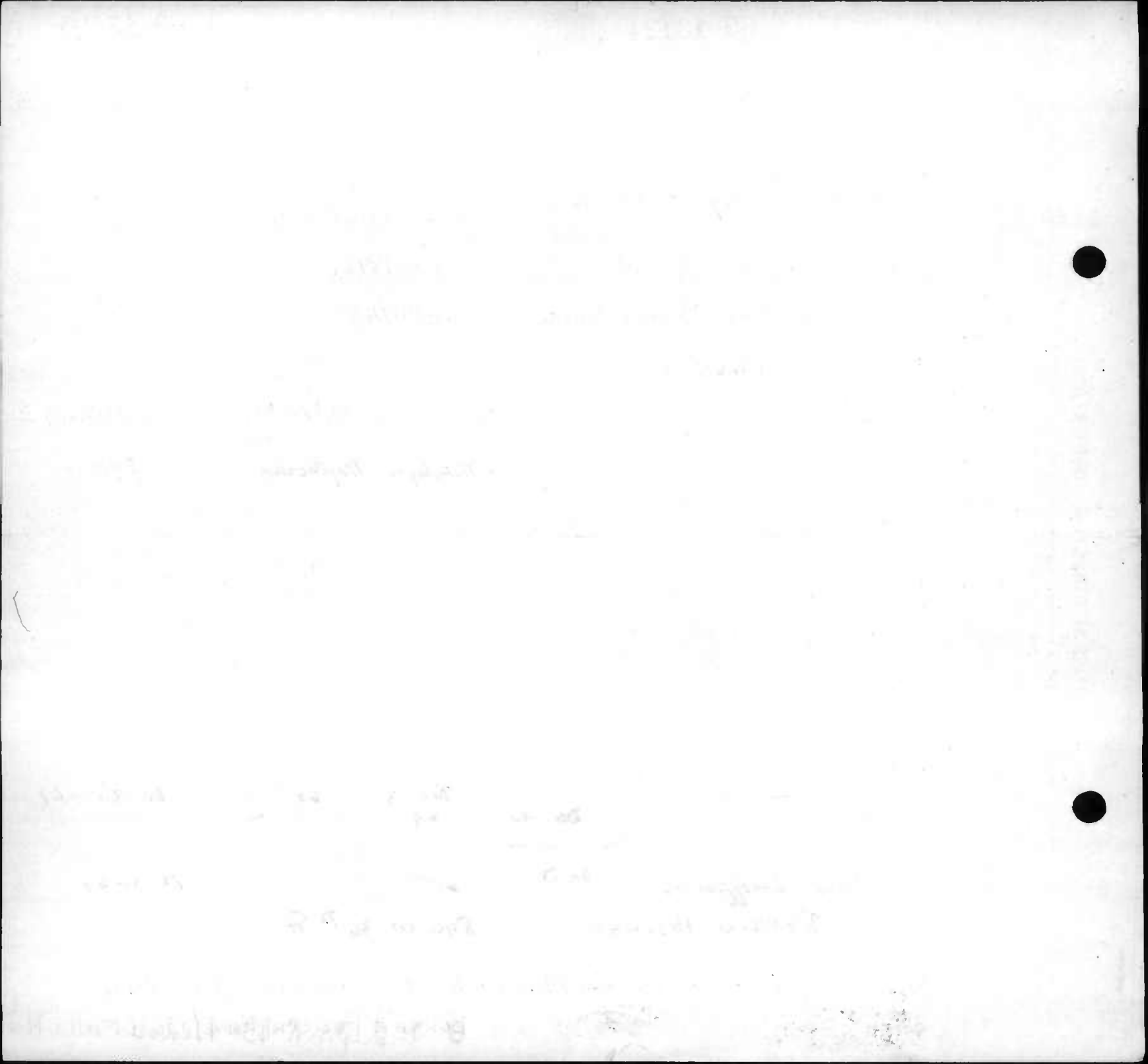
1. NAME OF DECEASED (Type or Print) PAMELA LUTTRELL		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 42 Sinai Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 12 28 69 1:05 P. M.	
6. SEX Female		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 1-19-1960		10. AGE (in years last birthday) 9	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William J. Luttrell		14. MOTHER'S MAIDEN NAME Wanda Elizabeth Bivens	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NO	
17. INFORMANT William J. Luttrell		ADDRESS 6919 Falls Road	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH E814.7 Multiple injuries (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Intersection Falls Rd. & Smith Avenue		22D. TIME (Month) (Day) (Year) (Hour) (Injury occurred) 12-21-69 12:25 P. M.	
22E. HOW DID INJURY OCCUR? Subj. pedestrian struck by car.		22F. HOW DID INJURY OCCUR? Subj. pedestrian struck by car.	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Russell S. Fisher, M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		DATE SIGNED 12-29-69	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12-31-69	
24C. NAME OF CEMETERY or CREMATORY MAYS CHAPEL CEM.		24D. LOCATION (City, town, or county) (State) BALTO CO. MD	
25A. DATE REC'D BY HEALTH DEPT. JAN 5 1970		25B. NAME OF REGISTRAR BURGESS	
25C. FUNERAL DIRECTOR BURGESS		ADDRESS 3631 FALLS ROAD	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-650		69 13124		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 13124	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) BESSIE T. BROWN				2. DATE AND HOUR OF DEATH DEC. 30, 1969 12 10 M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY 1306			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3625 Hickory Avenue				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 3625 Hickory Avenue			
5. SEX FEMALE	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 21, 1898	9. AGE (In years last birthday) 71	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RESERVATION CLERK		10B. KIND OF BUSINESS OR INDUSTRY PENNA RAILROAD		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Nelson Taylor				14. MOTHER'S MAIDEN NAME ROSE.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 812-07-4659A		17. INFORMANT Mrs Norma Lohr		ADDRESS 3625 Hickory Ave	
18. 203X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) multiple myeloma				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: multiple myeloma		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 years	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 10		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Dec 3 1968 to Dec 30 1969, that (I) (we) last saw the deceased alive on Dec 30 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (not) view the body after death.							
23A. SIGNATURE Reuben Hoffman M.D. OEGREE				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 12-31-69	
23C. PHYSICIAN'S NAME (Type) REUBEN HOFFMAN				23D. ADDRESS 846 W. 36th St.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1-2-70		24C. NAME OF CEMETERY or CREMATORY MORELAND MEM PARK CEM		24D. LOCATION (City, town, or county) (State) BALTO. Co. MD	
25A. DATE REC'D BY HEALTH DEPT. JAN 5 1970		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR BURIAL & FUNERAL HOME		ADDRESS 13631 Falls Rd	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>69 13125</u>	
B-610 69 13125 BIRTH NO. <u>109.23789</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>BABY BOY GROVE "A"</u>			2. DATE AND HOUR OF DEATH <u>DECEMBER 19 1969</u> <u>6:00 P.</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>SOUTH BALTIMORE GENERAL HOSPITAL</u> <u>43</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Howard</u> C. CITY OR TOWN <u>Laurel</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>5 Ruth St.</u>		
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DECEMBER 27 1969</u>	9. AGE (In years last birthday) <u>0</u> <u>2</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INFANT</u>			11. BIRTHPLACE (State or foreign country) <u>UNITED STATES</u>		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY? <u>UNITED STATES</u>		
13. FATHER'S NAME <u>RICHARD GROVE</u>			14. MOTHER'S MAIDEN NAME <u>SHEILA DUFFNEY</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>None</u>		
17. INFORMANT <u>Richard T. Grove</u>			ADDRESS <u>5 Ruth St. Laurel, Md 20810</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>776.1 I</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Hypoxia Myocardial Ischemia</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Heart Failure</u> (C)			CAUSE OF DEATH APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>DECEMBER 17</u> <u>19 69</u> to <u>DECEMBER 29</u> <u>19 69</u> , that (I) (we) lost saw the deceased alive on <u>DECEMBER 29</u> <u>19 69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Estrellita P. Trias M.D.</u>				23B. DATE SIGNED <u>DECEMBER 29 1969</u>	
23C. PHYSICIAN'S NAME (Type) <u>ESTRELLITA P. TRIAS M.D.</u>				23D. ADDRESS <u>SOUTH BALTIMORE GENERAL HOSPITAL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>1-2-70</u>		24C. NAME OF CEMETERY or CREMATORY <u>BALTIMORE NATIONAL</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 1 1970</u> 25B. NAME OF REGISTRAR <u>John F. ...</u>			
25C. FUNERAL DIRECTOR <u>High Information - Black</u>				ADDRESS <u>Elliot City, Md.</u>	

THE UNITED STATES

DEPARTMENT OF JUSTICE

CHIEF OF BUREAU

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RECEIVED

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-520		69 13126		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 13126	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <i>William Henes</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				2. DATE AND HOUR OF DEATH <i>Jan. 24 1969</i> M.			
FULL NAME OF HOSPITAL OR INSTITUTION <i>2803 Clifton Ave.</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>1506</i>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
5. SEX <i>M.</i> 6. RACE <i>Ch.</i> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <i>July 28, 1910</i> 59			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Scale Man Borden Heights N.C.</i>				11. BIRTHPLACE (State or foreign country)			
13. FATHER'S NAME <i>Victor Henes</i>				14. MOTHER'S MAIDEN NAME <i>Martha Collier</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO.			
17. INFORMANT <i>June Henes 2803 Clifton Ave.</i>				ADDRESS			
18. <i>170.21</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Pneumonia</i>			
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF: <i>Congestive heart failure</i>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) <i>Sarcoid of Thoracic Spines</i>			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20A. AUTOPSY (Yes or No) <i>No</i>				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (Month) (Day) (Year) (Hour)			
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>12/5/69</i> 19 to <i>12/24/69</i> 19 that (I) (we) last saw the deceased alive on <i>12/23/69</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>John J. Harris</i>				23B. DATE SIGNED <i>12/29/69</i>			
23C. PHYSICIAN'S NAME (Type) <i>Harris</i>				23D. ADDRESS <i>1801 Greenbury Rd, Baltimore, Md</i>			
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE			
24C. NAME OF CEMETERY OR CREMATORY <i>Burial Home</i>				24D. LOCATION (City, town, or county) (State) <i>Laurel, Md</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 5 1970</i>				25B. NAME OF REGISTRAR <i>John J. Harris</i>			
25C. FUNERAL DIRECTOR <i>William E. Elickson</i>				ADDRESS <i>1129 N. Charles St</i>			

Received of the Treasurer of the
County of Santa Clara
the sum of

40

Three hundred and no. 1001
10/23/04
10/22/04
10/21/04
10/20/04

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 13127	
BIRTH NO. 69 13127		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) RUTH MILES (nee Wells)		2. DATE AND HOUR OF DEATH 12/24/69 830 P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION JOHNS HOPKINS HOSPITAL		A. STATE MD.		B. COUNTY BALT. CITY	
ADDRESS OR LOCATION 33 BALTIMORE, MARYLAND		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 800 WEBB CT.			
5. SEX F	6. RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-19-06	9. AGE (In years last birthday) 63	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) V.A.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Willie Wells			
14. MOTHER'S MAIDEN NAME Wynnie Wells		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.		17. INFORMANT John Miles 800 Webb Ct			
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) HYOCARDIAL INFARCTION		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 HOURS			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). HEPATITIS, LIVER FAILURE					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/24/69 19 to 19, that (I) (we) last saw the deceased alive on 12/24/69 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Jerome L. Rubin				23B. DATE SIGNED 12/24/69	
23C. PHYSICIAN'S NAME (Type) Jerome Rubin				23D. ADDRESS STON. BRADWAY	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/31/69		24C. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cem.	
24D. LOCATION (City, town, or county) (State) A. A. County Md.		25A. DATE REC'D BY HEALTH DEPT. JAN 5 1970			
25B. NAME OF REGISTRAR John E. Rubin		25C. FUNERAL DIRECTOR Brooklyn, Baltimore 1129 N. Calver St			

10-9-00
T. J. Smith

PHYSICIAN IN CHARGE

HOSPITAL RECORDS

Yes

Refers

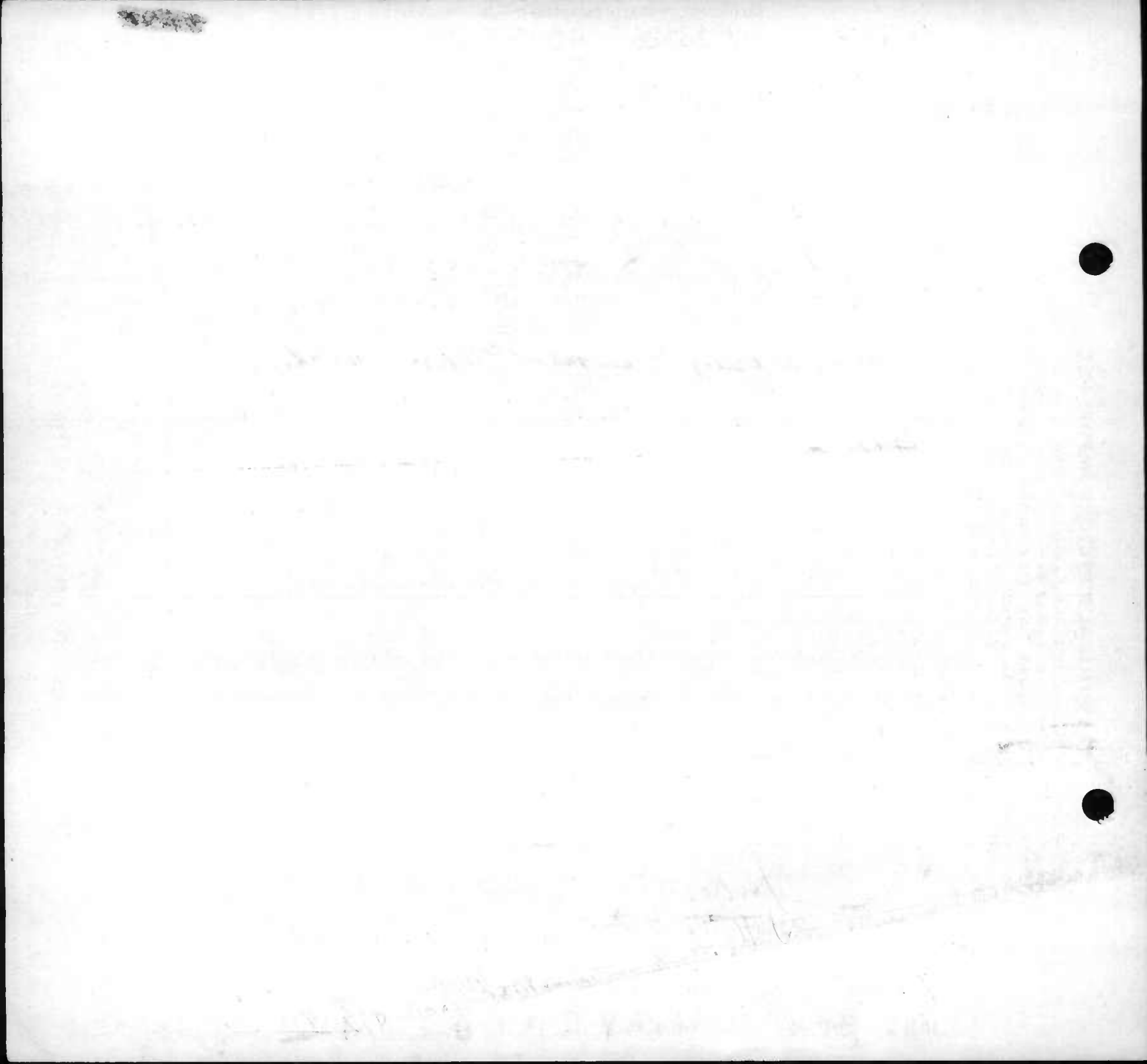
James L. Quinn
Refers

STON BROTHERS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

V-520		69 13128		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 13128	
BIRTH NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>YOUNG Emma</i>				12/26/69 7:20 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>1403</i>			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<i>Port Hill Nursing Home</i>		<i>1802 E. Canton Place</i>		E. STREET AND NUMBER			
5. SEX <i>Female</i>	6. RACE <i>N.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan 5, 1880</i>	9. AGE (In years last birthday) <i>89</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>James Wesley Newman</i>		14. MOTHER'S MAIDEN NAME <i>Mary Haskell</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>216 627766</i>	
		17. INFORMANT <i>Geraldine Waddell</i>		ADDRESS <i>2747 Clarendon</i>			
18. <i>412-2-1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Arteriosclerosis</i> (B) <i>Her D</i> (C) <i>Chronic Brain Synd</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 wks</i> <i>indly.</i> <i>11</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				<i>Dermatosis</i>		<i>11</i>	
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>18 Dec 1969</i> to <i>26 Dec 1969</i> , that (I) (we) last saw the deceased alive on <i>26 Dec 1969</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>J. Hulla M.D.</i>				23B. DATE SIGNED <i>26 Dec 69</i>			
23C. PHYSICIAN'S NAME (Type) <i>J. Hulla M.D.</i>		23D. ADDRESS <i>2214 E. Gay St</i>		23E. CITY, TOWN, OR COUNTY <i>Baltimore</i>		23F. STATE <i>Md.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Dec 31/69</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Carver Mem. Park</i>		24D. LOCATION (City, town, or county) (State) <i>1403</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 5 1970</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Ellen H. Taylor</i>		25D. ADDRESS <i>Home</i>	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 13129

BIRTH NO.

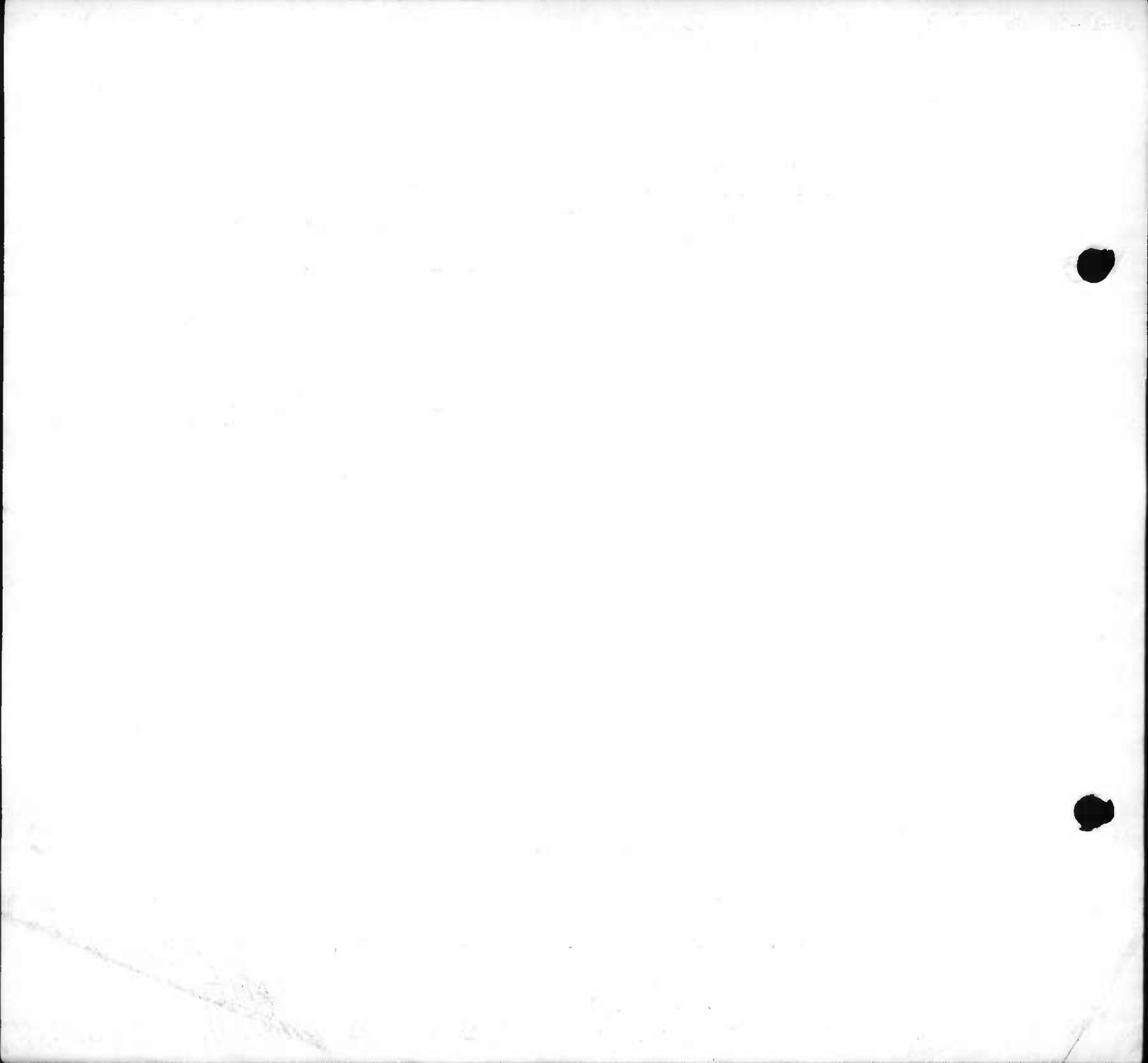
1. NAME OF DECEASED (Type or Print) ROOSEVELT STOKES		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1305 N. Fulton Avenue		3. DATE PRONOUNCED DEAD Month Day Year Hour 12 29 69 10:40A.M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH Oct 20, 1900		10. AGE (In years last birthday) 69	
11. BIRTHPLACE (State or foreign country) Greenbay W.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William Stokes		14. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 1502	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) mechanic		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME Jennie Morton		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS Willa Stokes 1305 Fulton Ave	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Hypertensive and arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) no			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE R. Fisher M.D. EXAMINER'S NAME (Type) Russell S. Fisher, M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12-29-69			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Jan 3/60	
24C. NAME OF CEMETERY or CREMATORY Mt Calvary Cem		24D. LOCATION (City, town, or county) (State) Ad County Md	
25A. DATE REC'D BY HEALTH DEPT JAN 5 1960		25B. NAME OF REGISTRAR Willa E. Ellickson	
25C. FUNERAL DIRECTOR Milton E. Ellickson		25D. ADDRESS 1129 N. Carroll St	

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ASTOR LENOX TILDEN FOUNDATION
500 5TH AVENUE
NEW YORK 17, N.Y.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 13130	
C-514		69 13130	
BIRTH NO.		69 13130	
1. NAME OF DECEASED (Type or Print) Roy CAMPBELL		2. DATE AND HOUR OF DEATH 12/22/69 1 5 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 31 BALTIMORE CITY HOSPITALS 4940 Eastern Avenue Baltimore, Maryland 21224		A. STATE Maryland B. COUNTY 808 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1029 Lemont Avenue 21205 007	
5. SEX Male	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-18-31
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		9. AGE (In years last birthday) 38	11. BIRTHPLACE (State or foreign country) Maryland
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Willie		14. MOTHER'S MAIDEN NAME Bessie	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT BCH-Records		ADDRESS 4940 Eastern Avenue Baltimore, Maryland 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE PULMONARY EMBOLUS DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) CONGESTIVE HEART FAILURE 7 months	
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 12/24/69 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED PULM. EMBOLUS 20A. AUTOPSY? (Yes or No) Yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH INSTANTANEOUS	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (H) (this hospital) attended the deceased from 1/17/69 to 12/22/69 that (H) (we) last saw the deceased alive on 12/22/69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Dennis W. Bleakley MD.		23B. DATE SIGNED 12/22/69	
23C. PHYSICIAN'S NAME (Type) Dennis W. Bleakley MD.		23D. ADDRESS BCH- 4940 Eastern Avenue Baltimore, Maryland 21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 12/24/69	24C. NAME OF CEMETERY OR CREMATORY Mt Auburn Cem.	24D. LOCATION (City, town, or county) (State) Westport, Md.
25A. DATE REC'D BY HEALTH DEPT. JAN 5 1970	25B. NAME OF REGISTRAR Robert E. Taylor	25C. FUNERAL DIRECTOR Milton B. Erickson 1129 N. Carrollist	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) Esther Mae Robinson		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 12 29 69 10:02 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 37 Mercy Hospital (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year Hour 12 29 69 10:02 P.M.	
6. SEX female		7. RACE colored	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1002	
9. DATE OF BIRTH Nov 10 / 43		10. AGE (In years last birthday) 26?	
11. BIRTHPLACE (State or foreign country) S.C.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME James Bowman		14. MOTHER'S MAIDEN NAME Dorothy Mae?	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		16. KIND OF BUSINESS OR INDUSTRY	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		18. SOCIAL SECURITY NO.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) E954X ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) water	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Pier 4 Pratt St. 401		22F. HOW DID INJURY OCCUR? fell off pier after shooting self	
22D. TIME OF INJURY (APPROX.) Month Day Year Hour 12 29 69 ? m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		21. AUTOPSY? (Yes or No) partial	
ACTUAL SIGNATURE Werner H. Spitz, M.D. EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12/30/69	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Jan 3 / 70	
24C. NAME OF CEMETERY or CREMATORY Mt Auburn Cem		24D. LOCATION (City, town, or county) (State) A.A. County	
25A. DATE REC'D BY HEALTH DEPT. JAN 5 1970		25B. NAME OF REGISTRAR Robert J. [unclear]	
25C. FUNERAL DIRECTOR Walter E. [unclear]		ADDRESS 1129 N. [unclear]	

VALLEY PARK CO

PLANT COUNTY

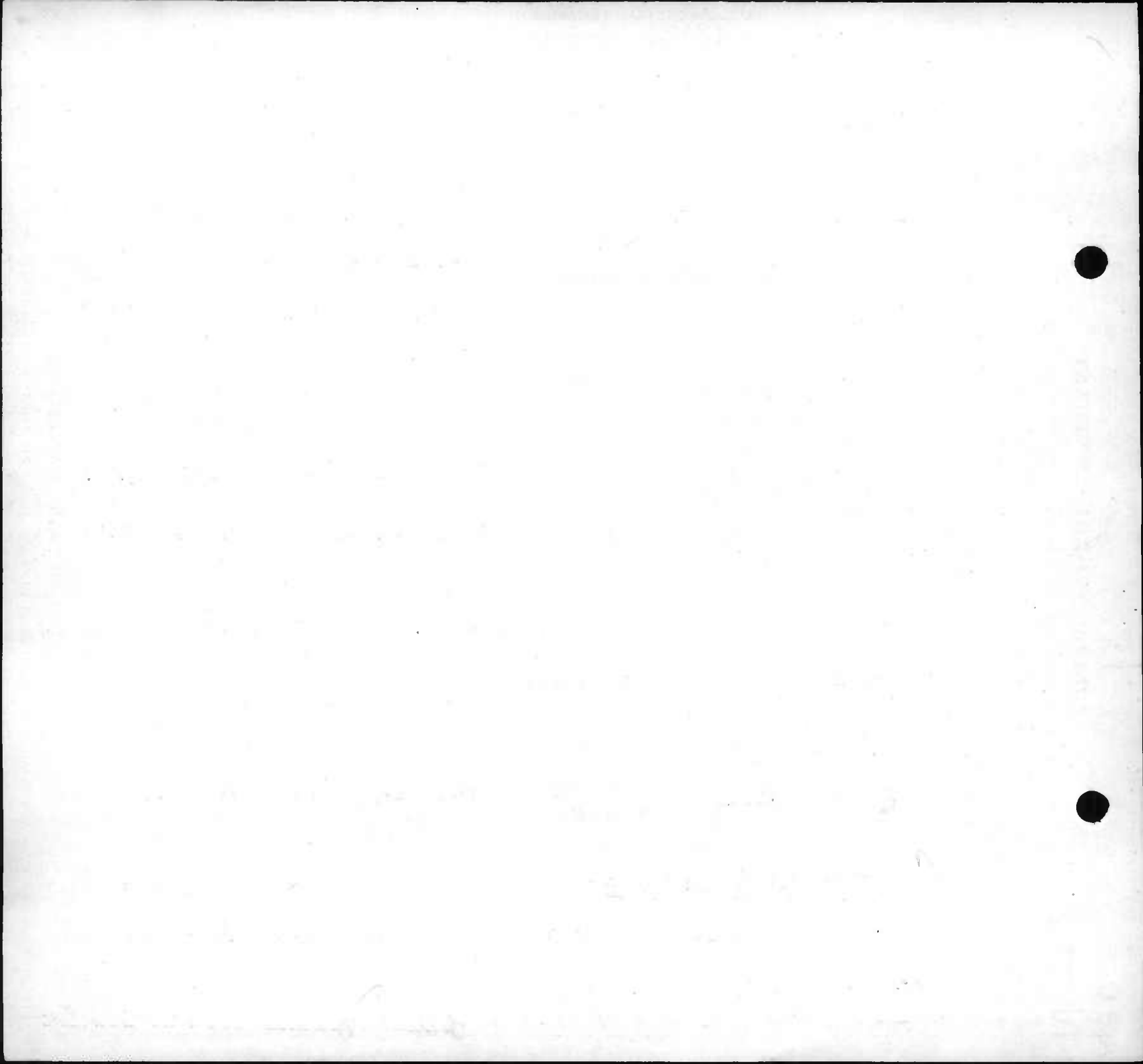
H. S. A.

21

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 13132	
J-525 69 13132		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Leonard Johnson		2. DATE AND HOUR OF DEATH 12/31/69 2:20 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 805		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Johns Hopkins Hospital		E. STREET AND NUMBER 1632 Danley Ave.			
5. SEX M	6. RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/12/88	9. AGE (In years last birthday) 81	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Balt. Md.	
13. FATHER'S NAME Samuel Smith		14. MOTHER'S MAIDEN NAME Ella Stokes		12. CITIZEN OF WHAT COUNTRY? U.S.A	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Marie Johnson 1632 Danley Ave.	
18. 5699 I		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiac arrest		15 min.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Massive pneumonia & hypoxia DUE TO, OR AS A CONSEQUENCE OF		30 hours	
(C)					
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		Operation for massive G.I. bleeding 6 days	
19A. DATE OF OPERATION 3 12/26/69		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Massive G.I. bleeding		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Dec. 24, 1969 to Dec. 31, 1969 , that (I) (we) last saw the deceased alive on 2:05 AM Dec. 31, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE David G. Ansel M.D.				23B. DATE SIGNED Dec. 31, 1969	
23C. PHYSICIAN'S NAME (Type) David G. Ansel		23D. ADDRESS M.D. 601 N. Broadway, Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Jan 5/70		24C. NAME OF CEMETERY OR CREMATORY Mt Calvary Cem	
24D. LOCATION A.A. County Md.					
25A. DATE REC'D BY HEALTH DEPT. JAN 5 1970		25B. NAME OF REGISTRAR Robert E. [unclear]		25C. FUNERAL DIRECTOR Griffith [unclear]	
				ADDRESS 1129 [unclear] St	



J-250

69 13133

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 13133

1. NAME OF DECEASED (Type or Print) Cornell W. Jackson		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 12 30 69 12:02a M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 37 Mercy Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 12 30 69 12:02a M.	
6. SEX male		7. RACE colored	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH July 4, 1949		10. AGE (In years last birthday) 20	
11. BIRTHPLACE (State or foreign country) Farmville Va.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Murice Kane		14. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 501	
15. MOTHER'S MAIDEN NAME Rodessa Jackson		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO.		18. INFORMANT Rose Jackson	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Stab wound of chest DUE TO, OR AS A CONSEQUENCE OF: (A) IMMEDIATE CAUSE (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes		22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 1200 Canal Ct. 501	
22D. TIME (Month) (Day) (Year) (Hour) (Approx.) 12 29 69 11:45pm		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? stabbed during altercation		23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> Deputy Chief Medical Examiner 12/30/69	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Jan 7/70	
24C. NAME OF CEMETERY or CREMATORY Mount Auburn Cem		24D. LOCATION (City, town, or county) (State) Westport md	
25A. DATE REC'D BY HEALTH DEPT JAN 5 1970		25B. NAME OF REGISTRAR John A. Elicker	
25C. FUNERAL DIRECTOR John A. Elicker		ADDRESS 11297 N. Calhoun St.	

RECEIVED BY FORM

F-320

69 13134 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 13134

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

James Foots

2. DATE
OF
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(If not in hospital or institution, give street
address or location)

44 Union Memorial Hospital

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

12

29

69

2:55 p.m.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Maryland

908

6. SEX

7. RACE

B. MARRIED ☐ NEVER MARRIED ☐

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

male

colored

WIDOWED ☒ DIVORCED ☐

Baltimore

YES ☐ NO ☐

9. DATE OF BIRTH

10. AGE (In years
last birthday)If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

11/16/1918

51

830 E. 22nd St.

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Littleton N.C.

James Foots

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

unemployed

Cora Boyd

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

yes

705-12-4018

Reba Neale 1534 Independence Ave

19. 412.41

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

2

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

22E. INJURY OCCURRED.

22F. HOW DID INJURY OCCUR?

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S

NAME (Type) Werner U. Spitz, M.D.

Deputy Chief Medical Examiner

DATE SIGNED

12/30/69

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

24C. NAME of CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

Burial

Jan 6/70

Mt. Vernon Natl Cem

5501 Fredrick Ave

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

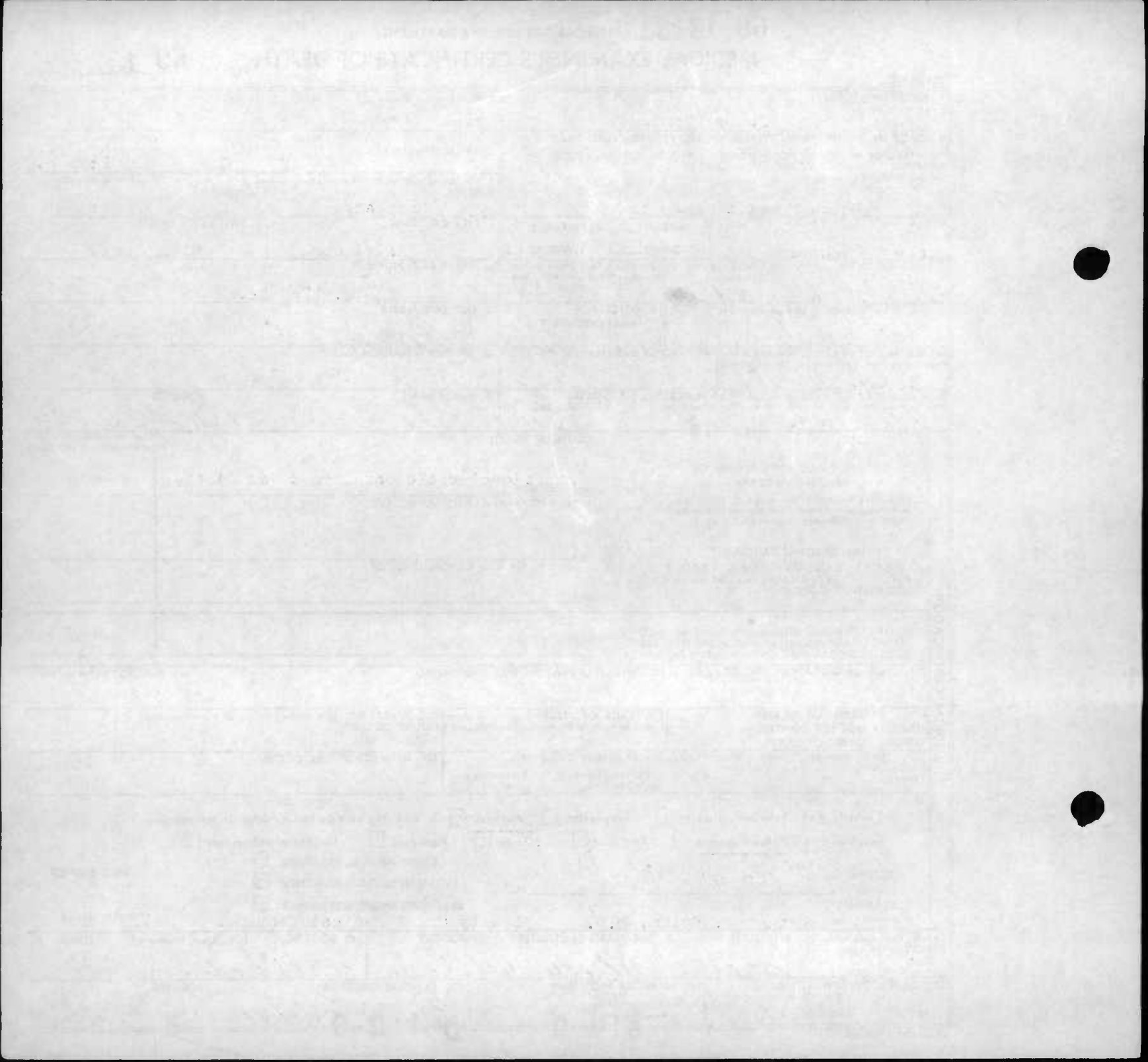
25C. FUNERAL DIRECTOR

ADDRESS

JAN 5 1970

Reba E. Neale

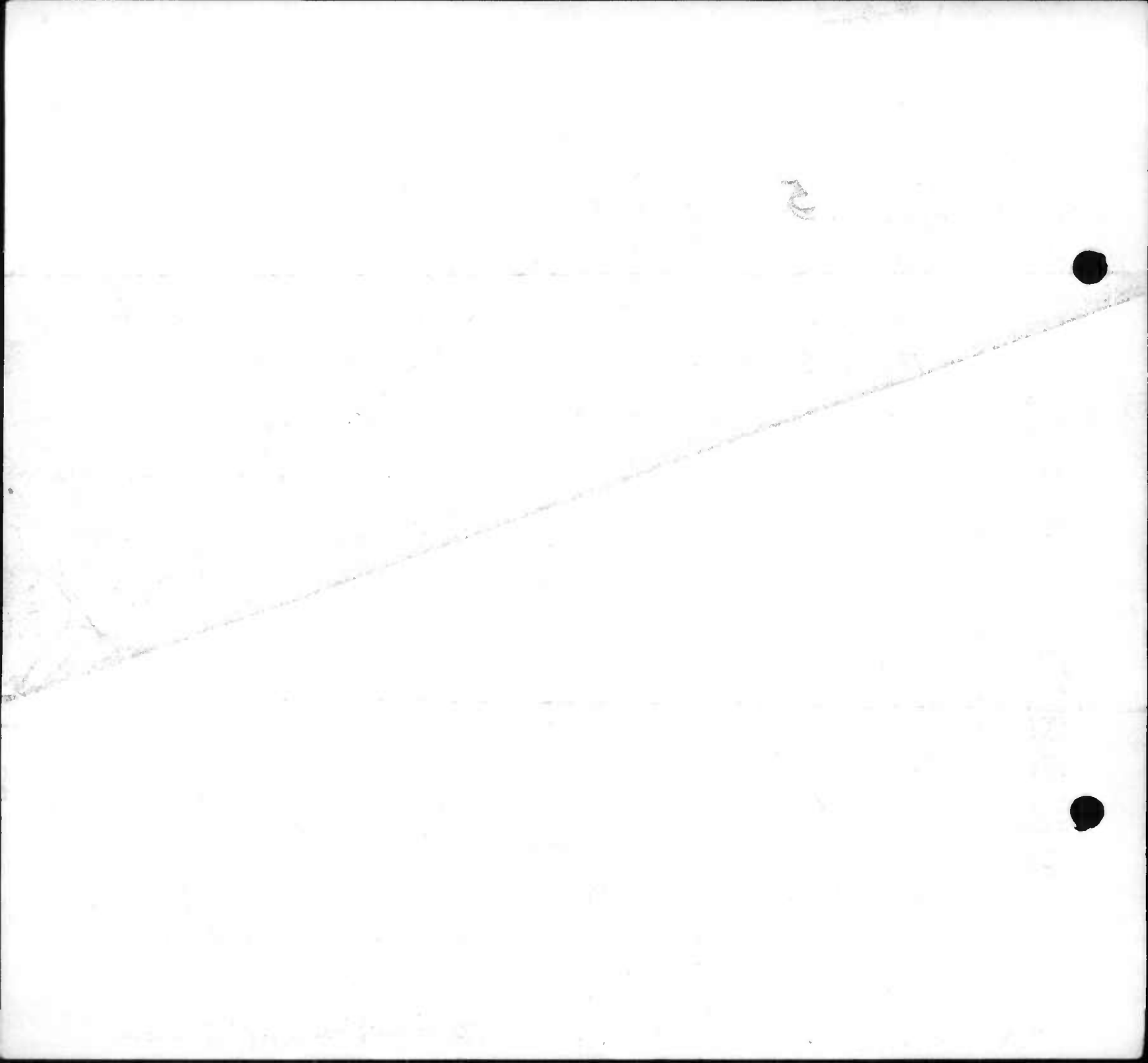
Frederick E. Neale 1129 N. Calvert



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-530		BALTIMORE CITY HEALTH DEPARTMENT		69 13135	
BIRTH NO.		69 13135		REG. NO.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Smith James Tolley		12/25/69 11:35 M.			
3. PLACE IN BALTIMORE MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY			
Full Name of Hospital or Institution (If not in hospital or institution, give street address or location) US Public Health Service Hospital Wyman Park Dr & 31st Street		C. CITY OR TOWN D. INSIDE CITY LIMITS? Baltimore, MD YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER 1927 Broadway					
5. SEX M	6. RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/23/02	9. AGE in years last birthday 67	10. If Under 1 Yr. Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) South Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Thomas E. Smith		14. MOTHER'S MAIDEN NAME Lela Antrum	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 200-09-1537		17. INFORMANT ADDRESS Pauline Brunson 1927 Broadway	
18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE Hepatic Coma DUE TO, OR AS A CONSEQUENCE OF: (B) Laryngeal Carcinoma DUE TO, OR AS A CONSEQUENCE OF: (C) Alcoholism		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 21 days yrs. yrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12-4-1969 to 12-25-1969 that (I) (we) last saw the deceased alive on 12-25-1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Daniel J. Rudomberg Jr. MD		23B. DATE SIGNED 12/25/69		23C. PHYSICIAN'S NAME (Type) DEGREE	
23D. ADDRESS OSPHS Hospital Baltimore, MD					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Dec 30/69		24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Park	
24D. LOCATION Arbutus Md					
25A. DATE REC'D BY HEALTH DEPT. JAN 5 1970		25B. NAME OF REGISTRAR Robert E. Huber, M.D.		25C. FUNERAL DIRECTOR Elliot's Funeral Home	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 13136

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

DOLORES SMITH

2. DATE OF DEATH Known ☐ Month Day Year Hour
Estimated ☐ 12 23 69 8:24 p. M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
1-28-70
Johns Hopkins Hospital D.O.A.3. DATE PRONOUNCED DEAD Month Day Year Hour
December 23, 1969 8:24 p. M.5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Maryland B. COUNTY 1205

6. SEX

Female

7. RACE

Negro

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☐ NO ☐

9. DATE OF BIRTH

1936

10. AGE (In years last birthday)

40-33

If Under 1 Yr. II Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

1808 Guilford Ave.

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

James Sallay

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

None

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Louise Stallings

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

17. SOCIAL SECURITY NO.

18. INFORMANT

Louise Sallay 1408 N. Dallas St

ADDRESS

19. E965X1

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE Shotgun wound of the abdomen
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

YES

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

Home

22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?

1808 Guilford Ave. 1205

22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

12 23 69 8:08m

22E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☒

22F. HOW DID INJURY OCCUR?

Subject shot

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL SIGNATURE
EXAMINER'S NAME (Type)

Ronald N. Kornblum, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/24/69

24A. BURIAL CREMATION, REMOVAL (Specify)

24B. DATE

Burial Dec. 29/69

24C. NAME OF CEMETERY or CREMATORY

Mt Calvary Cem.

24D. LOCATION (City, town, or county)

A.A. County

(State)

25A. DATE REC'D BY HEALTH DEPT.

JAN 5 1970

25B. NAME OF REGISTRAR

R. N. Kornblum

25C. FUNERAL DIRECTOR

Great E. E. E. 1129 N. Carroll St

ADDRESS

Birth Certificate E-52024 - 1936
and V.S. 153 1-28-70 M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

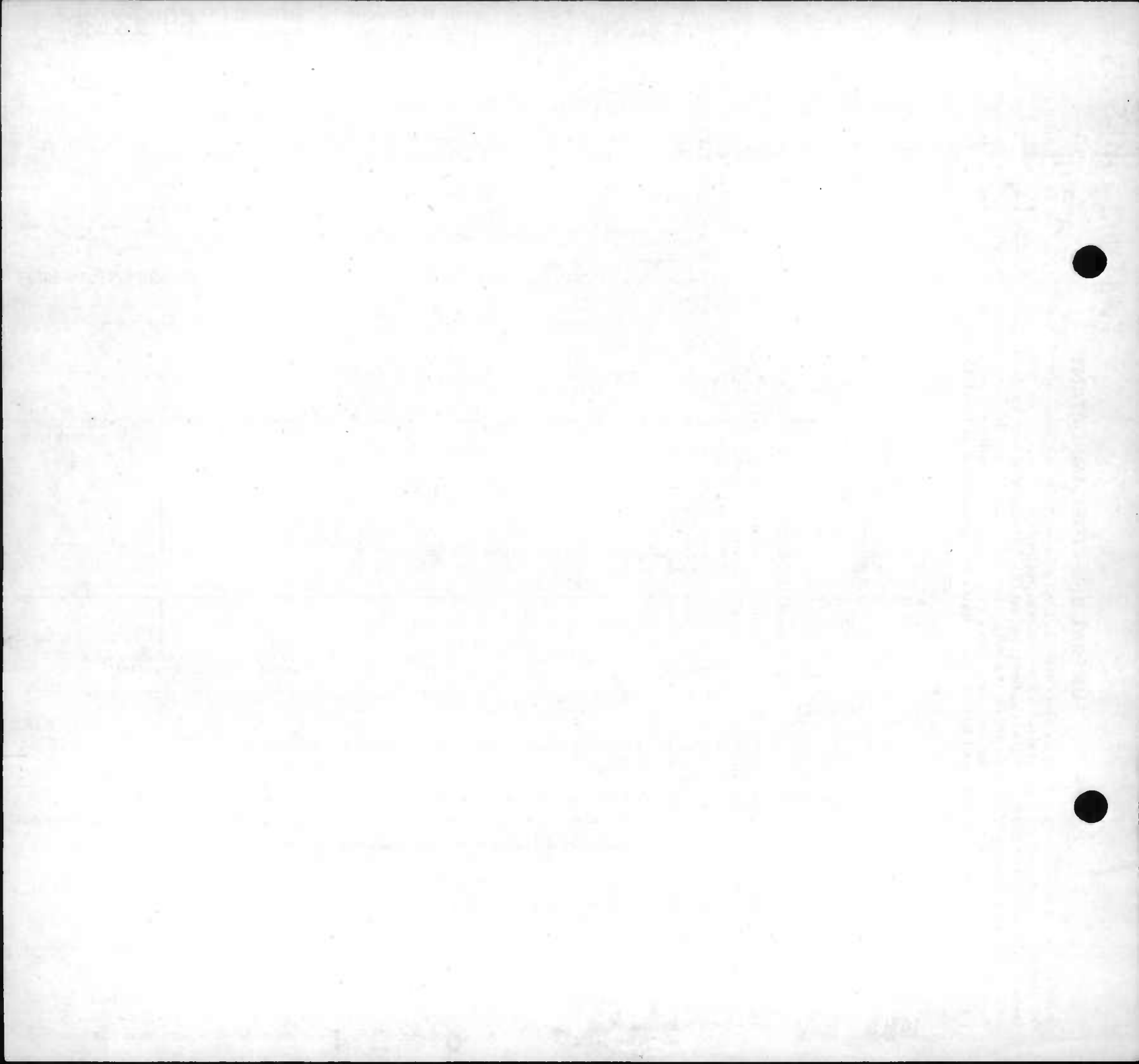
S-530		69 13137		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.		69 13137	
BIRTH NO.									
1. NAME OF DECEASED (Type or Print) <i>William H. Smith</i>					2. DATE AND HOUR OF DEATH <i>12-24-69 7:15 A</i>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION <i>34 Bon Secours Hospital</i>					A. STATE <i>Maryland</i> B. COUNTY <i>1901</i>				
(If not in hospital or institution, give street address or location)					C. CITY OR TOWN <i>Baltimore</i>			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
					E. STREET AND NUMBER <i>11 North Bruce St. J1223</i>				
5. SEX <i>M</i>		6. RACE <i>N</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <i>11-07-27</i>		9. AGE (In years last birthday) <i>42</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Labored</i>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>William Edward Smith</i>					14. MOTHER'S MAIDEN NAME <i>Louise Johnson</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes</i>				16. SOCIAL SECURITY NO. <i>217-20-0659</i>		17. INFORMANT <i>His chart</i>			
18. <i>492X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Pneumothorax</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>DAYS</i>	
					(B) <i>SEVERE PULMONARY EMPHYSEMA YEARS</i> DUE TO, OR AS A CONSEQUENCE OF:				
					(C) <i>LUNG ABSCESES</i>			<i>MONTHS</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION <i>2</i>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <i>Yes</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>12-23-69</i> to <i>12-24-69</i> that (I) (we) last saw the deceased alive on <i>12-24-69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Agustin del Campo MD</i>					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <i>12/24/69</i>	
23C. PHYSICIAN'S NAME (Type) <i>AGUSTIN del CAMPO MD</i>					23D. ADDRESS <i>Bon Secours Hosp. Balt. Md.</i>				
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>			24B. DATE <i>Dec 30/69</i>		24C. NAME OF CEMETERY or CREMATORY <i>Bald Natl. Cem</i>			24D. LOCATION (City, town, or county) (State) <i>5501 Fredrick Ave</i>	
25A. DATE RECD BY HEALTH DEPT. <i>12-25-1970</i>			25B. NAME OF REGISTRAR <i>900</i>			25C. FUNERAL DIRECTOR <i>Belmonte Funeral Home</i>			

11 N. Bruce St.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 13138
J-520 69 13138		CERTIFICATE OF DEATH		
BIRTH NO. 1				
1. NAME OF DECEASED (Type or Print) VIOLA JONES		2. DATE AND HOUR OF DEATH 12/24/69 1230 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MT SINAI NURSING HOME		A. STATE MARYLAND B. COUNTY 907		
		C. CITY OR TOWN BALTO		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER 1770 Homestead St		
5. SEX F	6. RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUN 24, 1914	9. AGE (In years 55 last birthday)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Hampton S.C.
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Henry Jones ADDRESS 1770 Homestead St
18. 1519 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Carcinoma of stomach ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carcinoma of stomach (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 YRS
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from March 1966 to Present 19____, that (I) (we) last saw the deceased alive on 12/20/69 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
23A. SIGNATURE Morton M. Power, M.D. DEGREE				23B. DATE SIGNED 12/24/69
23C. PHYSICIAN'S NAME (Type) MORTON M. POWER M.D. DEGREE		23D. ADDRESS 200 W. Cold Spring Rd. Balto. Md.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 12/30/69	24C. NAME OF CEMETERY OR CREMATORY Mt Calvary Cem		24D. LOCATION (City, town, or county) (State) Ad. County Md
25A. DATE REC'D BY HEALTH DEPT. JAN 5 1970		25B. NAME OF REGISTRAR Robert G. Jones		25C. FUNERAL DIRECTOR Milton E. Elickson ADDRESS 1129 N. Carroll



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				69 13139		REG. NO. 69 13139	
BIRTH NO. C-568				69 13139		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) EVA Letitia Conroy				2. DATE AND HOUR OF DEATH 12/29/69 1 PM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Hood Convalescent Home 5313 Edmondson Ave. Balto. 21229				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE md. B. COUNTY 39110.00 5300 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 70 Severnsky Ct.			
5. SEX Female	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-3-1890	9. AGE (In years last birthday) 79	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William D. Conroy				14. MOTHER'S MAIDEN NAME Hamilton.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-03-7869		17. INFORMANT MRS. EDNA MEAGHER, BALTIMORE, MD. 21221			
18. 309.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). C.B.S. Varicose Veins, Severe, bilater				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pneumonia (B) DUE TO, OR AS A CONSEQUENCE OF: C.B.S. and Scurvy (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days. Years.	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 12-3-30 1967 to 12-28 1969, that (I) (we) last saw the deceased alive on 12/29/ 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Adnan M. Sumner				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) Adnan M. Sumner				23D. ADDRESS 1011 Frederick Rd. Md. 21228			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE JAN. 2, 1970		24C. NAME OF CEMETERY or CREMATORY ST. MICHAELS CATHOLIC		24D. LOCATION (City, town, or county) (State) FROSTBURG, MD.	
25A. DATE REC'D BY HEALTH DEPT. JAN 5 1970		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR JOSEPH B. DURST		ADDRESS FROSTBURG, MD. 21532	

Information from
Hood Nursing Home - address of deceased
70 Siversky Ct. Balto. Co. 21221

B-6521

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 13140

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO. 69 13140

BIRTH NO.		69 13140		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 13140	
1. NAME OF DECEASED (Type or Print) <u>William Barnes</u>				2. DATE AND HOUR OF DEATH <u>12/30/69</u> <u>8:15 A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>2101</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Univ of Md. Hosp</u>				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				E. STREET AND NUMBER <u>546 S. PACA ST</u>			
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/25/98</u>	9. AGE (In years last birthday) <u>71</u>	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>George T Barnes</u>				14. MOTHER'S MAIDEN NAME <u>Miriam Bowie</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) [If yes, give war or dates of service]				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hilda Barnes</u> ADDRESS <u>644 Portland St.</u>	
18. <u>444.2</u> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>HEPATIC COMA</u>		<u>days</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <u>GANGRENE SMALL INTESTINE</u> DUE TO, OR AS A CONSEQUENCE OF: <u>EMASSIVE RESECTION</u>		<u>8 days</u>	
				(C) <u>Superior Mes. Arty. Thromb.</u>		<u>9 days</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				<u>ATRIAL Fibrillation</u>			
19A. DATE OF OPERATION <u>12/22/69</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>GANGRENE SMALL INTESTINE</u>		20A. AUTOPSY? (Yes or No) <u>yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>STREET</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>12/2/69</u> ?		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>ASSAULT</u>			
22. I certify that (we) (this hospital) attended the deceased from <u>12/15</u> 19 <u>69</u> to <u>12/30</u> 19 <u>69</u> that (we) lost saw the deceased alive on <u>12/30</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>J. Frank Hartman II</u>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>12/30/69</u>	
23C. PHYSICIAN'S NAME (Type) <u>J. FRANK HARTMAN II MD</u>				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>1/5/70</u>		24C. NAME OF CEMETERY or CREMATORY <u>Baltimore National</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore National</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 5 1970</u>		25B. NAME OF REGISTRAR <u>P. E. Tabor, M.D.</u>		25C. FUNERAL DIRECTOR <u>CHARLES A. RICE</u>		ADDRESS <u>661 W. BARRE ST.</u>	

May 1911

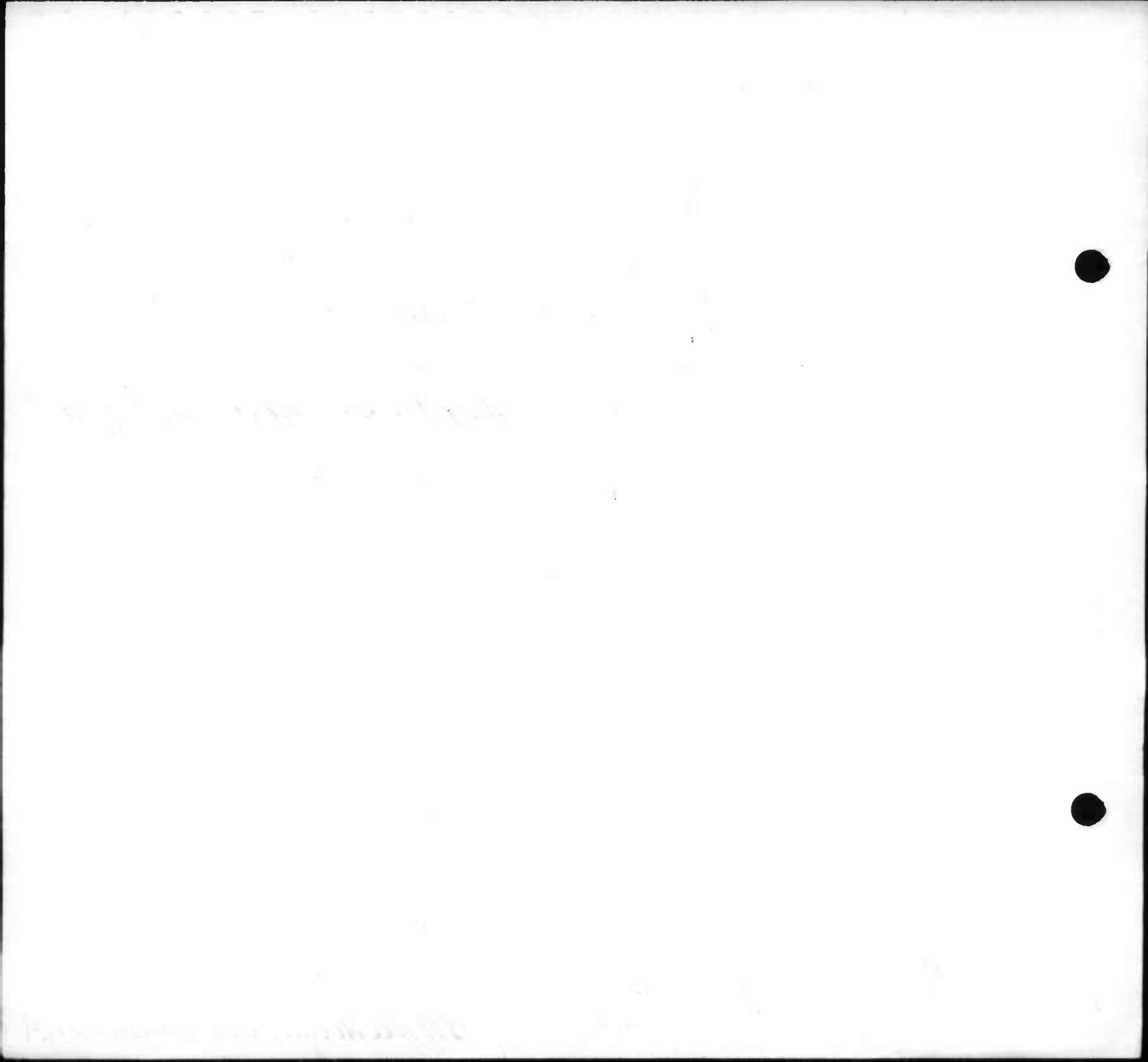
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-230 69 13141				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 13141	
1. NAME OF DECEASED (Type or Print) Alfred Clinton West				2. DATE AND HOUR OF DEATH 12-30-69 2:55 p.m.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 46 Lutheran Hospital				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 15 11			
5. SEX Male 6. RACE Colored 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH Dec -2-1899		9. AGE (In years last birthday) 70yr	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Balto, Md.	
13. FATHER'S NAME George F. West (Dec.)				14. MOTHER'S MAIDEN NAME Rinthia Treherne (DEC.)			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 213-01-0656A		17. INFORMANT ADDRESS Mrs Beatrice Christian - 3407 Ellamont St	
18. 250.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardio Respiratory Failure ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral Vascular Hemorrhage (B) Hypertensive - Art CVD (C) Diabetes Mellitus				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Jan 29 1968 to Dec 30 1969 , that (I) (we) last saw the deceased alive on Dec 30 1969 and that in (my) (an) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.							
23A. SIGNATURE William D Applefeld				23B. DATE SIGNED 12/31/69		23C. PHYSICIAN'S NAME (Type) William D Applefeld	
23D. ADDRESS 6615 Newkirk Rd		24A. BURIAL CREMATION, REMOVAL (Specify) Burial					
24B. DATE 1-3-70		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn		24D. LOCATION (City, town, or county) (State) Baltimore Md.			
25A. DATE REC'D BY HEALTH DEPT. JAN 5 1970		25B. NAME OF REGISTRAR Robert E. Galt		25C. FUNERAL DIRECTOR ADDRESS William F. Phillips 1727 Monroe St.			

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

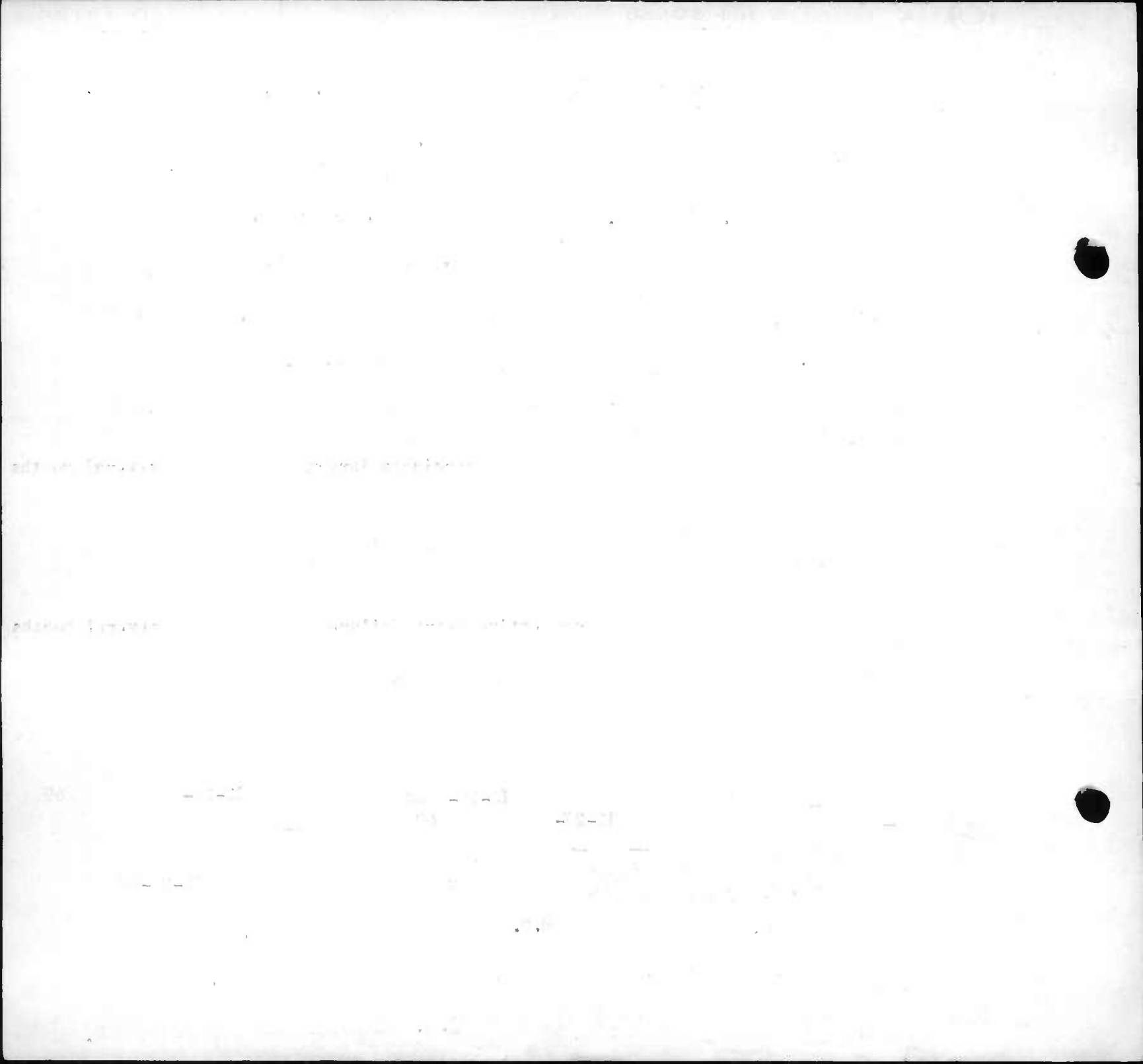
M-252		69 13142		BALTIMORE CITY HEALTH DEPARTMENT		69 13142	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
CHARLES Mc GONNAGILL				12/30/69 6:20 p.m.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital				A. STATE MD B. COUNTY 2735			
(If not in hospital or institution, give street address or location)				C. CITY OR TOWN BALTO D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
44				E. STREET AND NUMBER 3116 E NORTHERN PARKWAY			
5. SEX M		6. RACE CAU.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/19/86	
						9. AGE (In years last birthday) 83	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Foreman		Hufford & Boya		Baltimore		U.S.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 215-01-5240 A		17. INFORMANT ADDRESS	
						Mr John Bernickol 3116 E. Northern	
18. 485 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: BRONCHOPNEUMONIA			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (this hospital) attended the deceased from 12/26/69 to 12/30/69 that (I) lost saw the deceased alive on 12/30/69 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.							
23A. SIGNATURE [Signature] DEGREE				Attending <input type="checkbox"/> Phys. Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 12/30/69	
23C. PHYSICIAN'S NAME (Type) S. H. V. RIBEIRO DEGREE				23D. ADDRESS Union Memorial Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/2/70		24C. NAME OF CEMETERY or CREMATORY Woodlawn		24D. LOCATION (City, town, or county) (State) Balto.	
25A. DATE REC'D BY HEALTH DEPT. JAN 5 1970		25B. NAME OF REGISTRAR Robert E. [Signature]		25C. FUNERAL DIRECTOR [Signature]		ADDRESS 6067 Halifax Rd	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. of a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

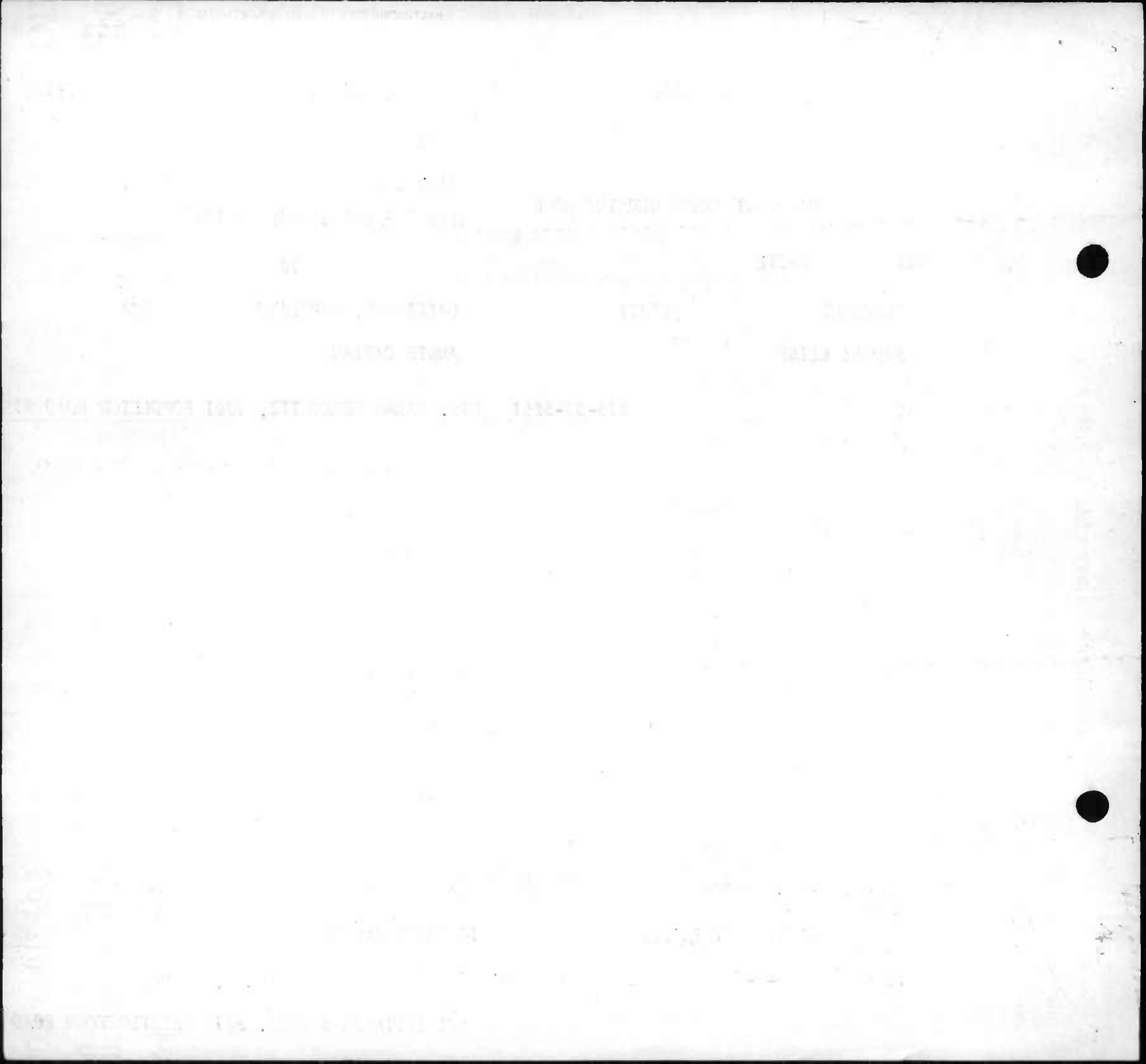
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 13143	
M-635 69 13143				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		John Robert Martin		Dec. 28, 69 10.30 p.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE	
				Md.	
2009 E. 32nd St.				C. CITY OR TOWN	
				Baltimore	
				D. INSIDE CITY LIMITS?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER	
				2009 E. 32nd St.	
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
M	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Feb. 27, 96	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday)	
Clerk		Register of Wills		72	
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?	
Westminster Md.				U.S.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME	
John R. Martin				Alice Stouch	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
Yes Navy		214 01 1678A		Ann Martin	
18. CAUSE OF DEATH				ADDRESS	
<p>I</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
				several months	
<p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p>				congestive heart failure	
				several months	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 10-20-64 to 12-28-69, that (I) (we) last saw the deceased alive on 12-27-69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
E. Ellsworth Cook				12-29-69	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
E. Ellsworth Cook M.D.				2431 Maryland Ave.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		12/31/69		Parkwood	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JAN 5 1970		Robert E. Galt		E.A. Heemann	
				ADDRESS	
				6067 Hartford RD.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 13144	
8-450 69 13144		CERTIFICATE OF DEATH			
BIRTH NO. 1. NAME OF DECEASED (Type or Print) FRANK KLINE		2. DATE AND HOUR OF DEATH DECEMBER 31, 1969 11:30a.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 PLEASANT MANOR NURSING HOME		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY MARYLAND 2720 C. CITY OR TOWN D. INSIDE CITY LIMITS? BALTIMORE YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4003 FORDLEIGH ROAD #21215			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 70	9. AGE (In years lost birthday) 70	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MERCHANT
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MERCHANT		10B. KIND OF BUSINESS OR INDUSTRY RETAIL		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME SAMUEL KLINE		14. MOTHER'S MAIDEN NAME ANNIE CAPLAN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 215-30-3251		17. INFORMANT ADDRESS MRS. SARAH BERKOWITZ, 4001 FORDLEIGH ROAD #15	
18. CAUSE OF DEATH 156.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Caecoma, gall bladder > 2 yrs ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 12-31-69		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 156.0 I		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 11 SLADE AVENUE		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 11 SLADE AVENUE	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 12-31-69		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? 12-31-69	
22. I certify that (I) (this hospital) attended the deceased from 11-19-69 to 12-31-69 , that (I) (we) last saw the deceased alive on 12-31-69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Stanley K Steinback, M.D.				23B. DATE SIGNED 1/2/69	
23C. PHYSICIAN'S NAME (Type) STANLEY STEINBACK		23D. ADDRESS 11 SLADE AVENUE			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1-2-70		24C. NAME OF CEMETERY OR CREMATORY CHIZUK AMUNO (ARLINGTON)	
24D. LOCATION (City, town, or county) (State) ROGERS AVENUE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. JAN 5 1970			
25B. NAME OF REGISTRAR John E. Taylor, R.D.		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS. 6010 REISTERSTOWN ROAD			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> K-623 69 13145 BALTIMORE CITY HEALTH DEPARTMENT </div>		CERTIFICATE OF DEATH		REG. NO. 69 13145	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Milton Krastman		2. DATE AND HOUR OF DEATH 12/31/69 2:30 PM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 45 Good Samaritan Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2719 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 5521 GIST AVE 21215			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 02-10-04	9. AGE (In years last birthday) 65	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PLUMBER		10B. KIND OF BUSINESS OR INDUSTRY EMPLOYEE		11. BIRTHPLACE (State or foreign country) RUSSIA	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME PHILIP KRASTMAN		14. MOTHER'S MAIDEN NAME ANNA MANN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 220-18-8482		17. INFORMANT MR. HARRY KRASTMAN, 5521 GIST AVENUE #15	
18. 517X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Fibrotic lung disease Pneumothorax (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1-2 years 5 hours	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/31/69 19 to 12/31/69 19, that (I) (we) lost saw the deceased alive on 12/31/69 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Kevin N. Hennessey, MD.				23B. DATE SIGNED 12/31/69	
23C. PHYSICIAN'S NAME (Type) Kevin N. Hennessey, MD.				23D. ADDRESS Good Samaritan Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1-2-70		24C. NAME OF CEMETERY or CREMATORY SHAAREI ZION	
24D. LOCATION (City, town, or county) (State) ROSEDALE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. JAN 5 1970			
25B. NAME OF REGISTRAR John E. Fisher, MD.		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS. 6010 REISTERSTOWN RD.			

WHITE

SALE

WEST

CHURCH

PLUM

AMERICAN

WILLIAMSON

200 S. 1st St. - 1st Floor - 1st Floor - 1st Floor

100 S. 1st St. - 1st Floor - 1st Floor - 1st Floor

100 S. 1st St. - 1st Floor - 1st Floor - 1st Floor

69 13146

CERTIFICATE OF DEATH

REG. NO.

69 13146

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

SHELDON P. BERMAN

2. DATE AND HOUR OF DEATH

DEC 31, 1969 5:00 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

4940 Eastern Avenue

Baltimore, Maryland 21224

FULL NAME OF
HOSPITAL OR
INSTITUTION

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

6105 Robin Hill Road 21207 007

5. SEX

Male

6. RACE

White

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

3-1-26

9. AGE (In years
last birthday)

43

10. Under 1 Yr.

Months: Days:

11. Under 24 Hrs.

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

PROPRIETOR

10B. KIND OF BUSINESS OR INDUSTRY

REAL ESTATE

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Meyer BERMAN

14. MOTHER'S MAIDEN NAME

Rae SELKIVTZ

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

YES

WWII ARMY

16. SOCIAL
SECURITY NO.

220-12-7984

17. INFORMANT

MRS. RENEE BERMAN

ADDRESS

4940 Eastern Avenue
Baltimore, Maryland 21224

SAME

18.

202.2 I

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

RENAL FAILURE

1 WEEK

(B)

DUE TO, OR AS A CONSEQUENCE OF:

LYMPHOMA

1 YEAR

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

None

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

None

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)

NO

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

None

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

None

22. I certify that (I) (this hospital) attended the deceased from DEC 23 19 69 to DEC 31 19 69
that (I) (we) last saw the deceased alive on DEC 31 19 69 and that (my) (our) opinion death occurred on the date
and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Hubert W. Gerry MD

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

DEC 31, 1969

23C. PHYSICIAN'S
NAME (Type)

Hubert W. Gerry

DEGREE

23D. ADDRESS

4940 Eastern Avenue

21224

24A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

24B. DATE

1-2-70

24C. NAME of CEMETERY or CREMATORY

BETH TFILOH,

24D. LOCATION

(City, town, or county)

(State)

WINDSOR MILL ROAD, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.

JAN 5 1970

25B. NAME OF REGISTRAR

Robert E. Fisher

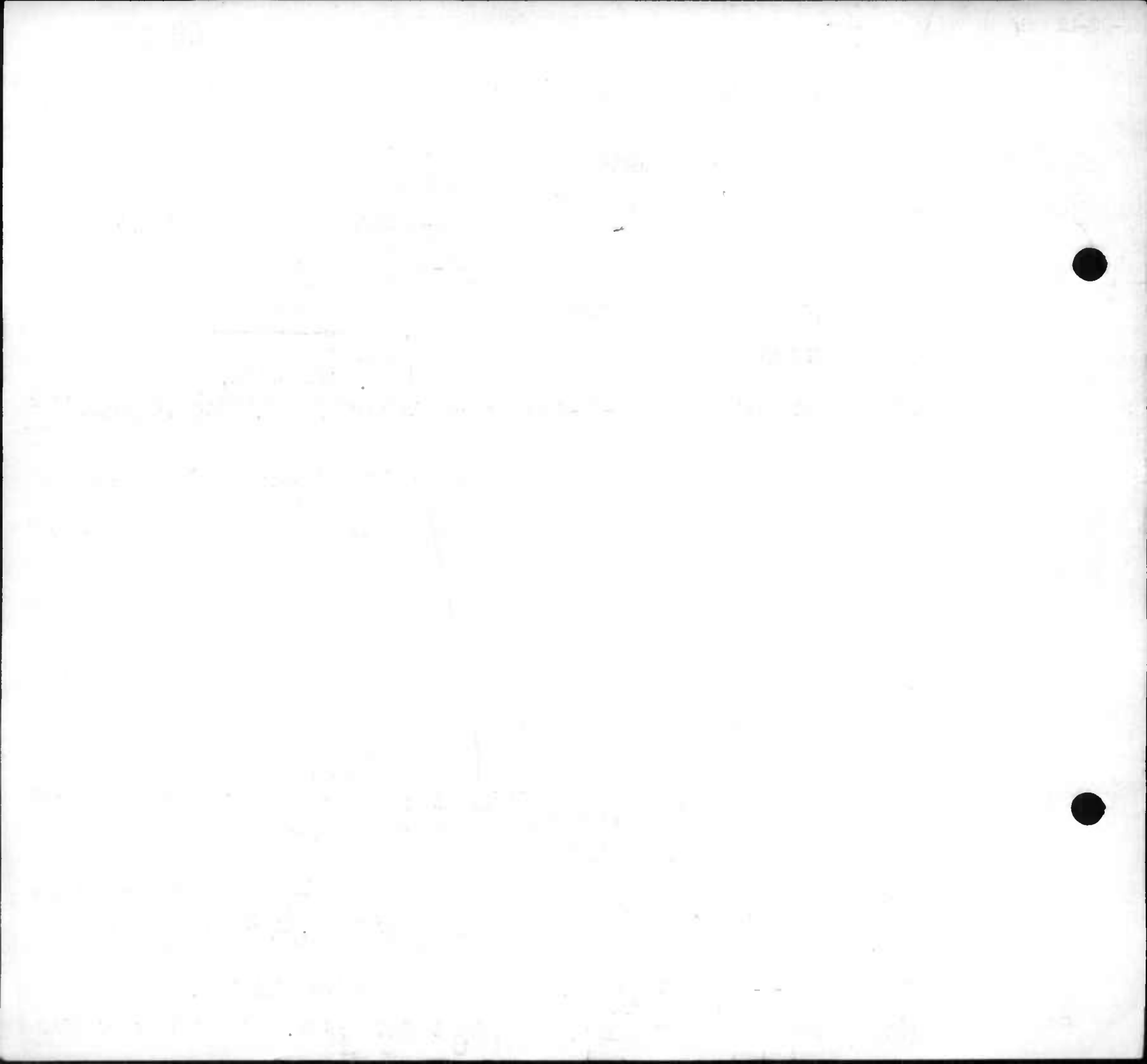
25C. FUNERAL DIRECTOR

ADDRESS

SOL LEVINSON & BROS. 6010 REISTERSTOWN ROAD

FUNERAL DIRECTOR: IMPORTANT

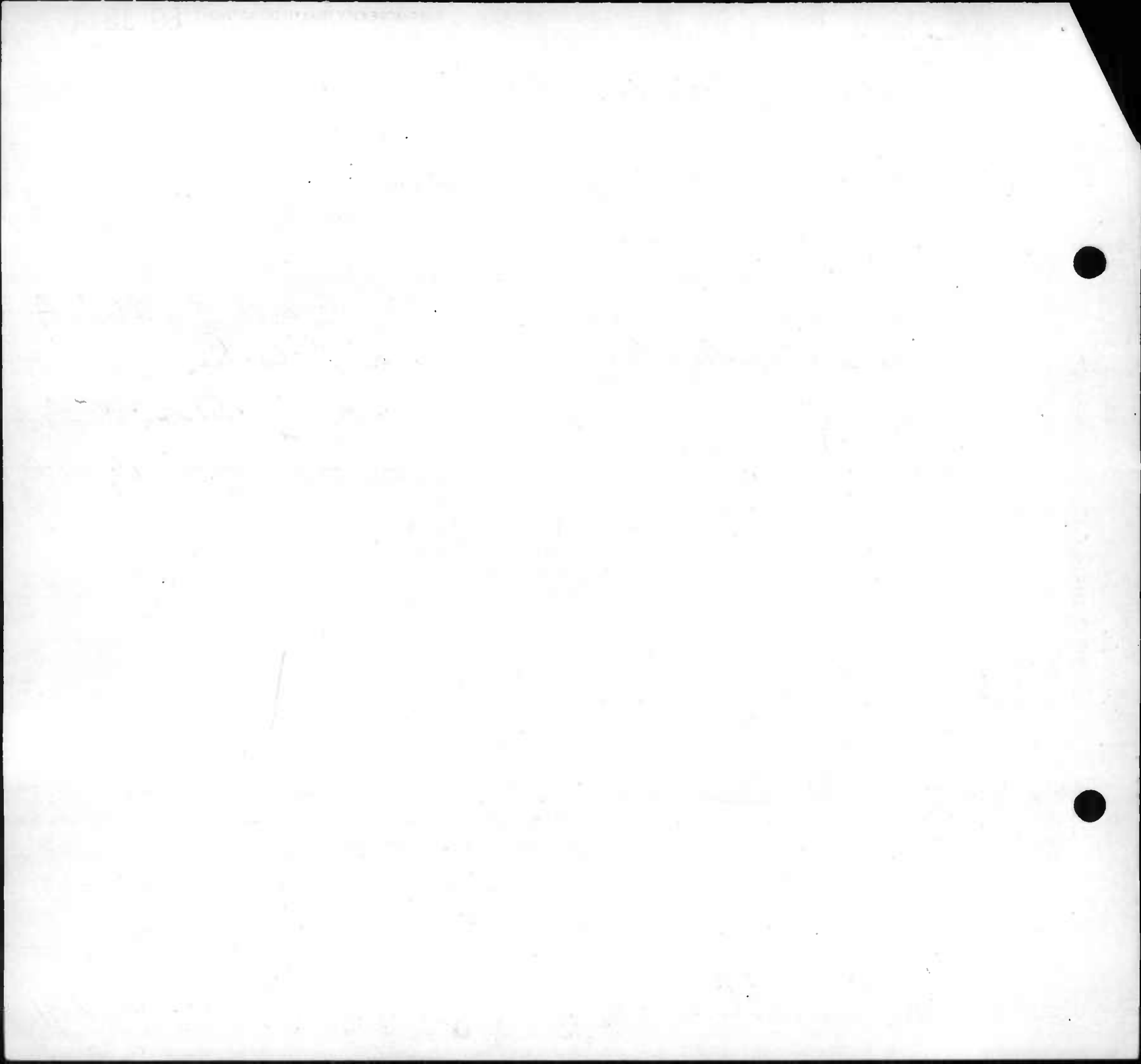
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital. The body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> F-652 69 13147 </div>		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		69 13147 REG. NO.	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Alice Rottenberg Frombes		12/31/69 4 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		A. STATE	
		Maryland		2831	
FULL NAME OF HOSPITAL OR INSTITUTION		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
00 6504 Eberle Dr. apt 101		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		6504 Eberle Dr. apt 101			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days
Female	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		63	If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife		Home		Baltimore, Md.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Maurice Rottenberg		Rose Pressler		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO				Arthur Frombes - Same	
18. 206.9 I		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		18 months	
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		Spontaneous paraplegia			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:		2 years	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		Monocyte leukemia			
		(C) _____			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 1948 to 12-31-1969, that (I) (we) last saw the deceased alive on Dec 24 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Herbert Gundersheimer M.D. DEGREE				12-31-69	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Herbert Gundersheimer M.D.		Lake Drive & Linden Ave			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		1/2/70		Hebrew Friendship	
25A. DATE RECEIVED BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JAN 5 1970		001		6010 Reist Rd.	



1

69 13148

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 13148

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

SUSAN NASDOR

2. DATE
OF
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

UNION MEMORIAL HOSPITAL (DOA)

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

December 30, 1969

10:15 P.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

6. SEX

Female

7. RACE

White

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore/Randallstown

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

9-12-53

10. AGE (In years
last birthday)

16

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

3708 ~~JULIAN CT~~ JULIAN COURT #21133

11. BIRTHPLACE (State or foreign country)

BALTIMORE, MARYLAND

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

GEORGE H. NASDOR

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

SCHOOL

14B. KIND OF BUSINESS OR INDUSTRY

AT SCHOOL

15. MOTHER'S MAIDEN NAME

PATRICIA CUDDIHEE

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

MR. GEORGE H. NASDOR, 3708 JULIAN COURT #21133

19.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

CAUSE OF DEATH

Multiple Traumatic Injuries

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

Street

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Jones Falls Expressway-114 ft. S. of 5.7

22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.) 12-30-69 9:30 P.

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Passenger in auto-auto collision

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Ronald N. Kornblum, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/31/69

24A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

24B. DATE

1-2-70

24C. NAME of CEMETERY or CREMATORY

BETH YEHUDA ANSHE KURLAND

24D. LOCATION (City, town, or county)

BOWLEYS LANE, MARYLAND

(State)

25A. DATE REC'D BY HEALTH DEPT.

JAN 5 1970

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

SOL LEVINSON & BROS. 6010 REISTERSTOWN ROAD

7-11-52

BALTIMORE, MARYLAND

(2)

GEORGE H. WARDON

AT SCHOOL

SCHOOL

PATRICIA CRODINE

IN

MR. GEORGE H. WARDON, 5204 JULIAN COURT #1113

METI VERA AND KURLAND BOWERS LANE, BALTIMORE

1-1-10

LEGAL

201 LIVING & SHOP, 4010 WESTBURY ROAD

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.
A-165		69 13149		69 13149
BIRTH NO.				
1. NAME OF DECEASED (Type or Print) HANNAH ABRAMSON			2. DATE AND HOUR OF DEATH 6:30 12/31/69 A 6:30 4.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 JOHNS HOPKINS HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY Baltimore C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2325 Micarol Road 21209	
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 01/18/01	9. AGE (In years last birthday) 68
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Executive		10B. KIND OF BUSINESS OR INDUSTRY Retail - Grocers		11. BIRTHPLACE (State or foreign country) New York City
13. FATHER'S NAME Mendel Levy			14. MOTHER'S MAIDEN NAME Bessie Kresner	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Laurell E. Abramson ADDRESS 2325 Micarol Rd
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH PNEUMONIA (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. HODGKINS DISEASE			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3d. 6 MONTHS	
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 12/29 19 69 to 12/31 19 69 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 12/31 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.				
23A. SIGNATURE Karl S. Kramer M.D. DEGREE				23B. DATE SIGNED 12/31/69
23C. PHYSICIAN'S NAME (Type) Karl S. Kramer, M.D.		23D. ADDRESS The Johns Hopkins Hospital		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 1-2-70	24C. NAME OF CEMETERY or CREMATORY Washington Cemetery		24D. LOCATION (City, town, or county) (State) Brooklyn, N.Y.
25A. DATE REC'D BY HEALTH DEPT. JAN 5 1970		25B. NAME OF REGISTRAR Robert E. [unclear]		25C. FUNERAL DIRECTOR Ed [unclear] & Bros
ADDRESS 6010 Rustuslaw Road				

69 13150

CERTIFICATE OF DEATH

REG. NO.

69 13150

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Higgs, Clarence

2. DATE AND HOUR OF DEATH

12/29/69

10:20P

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

BALTIMORE CITY HOSPITALS

4940 EASTERN AVENUE

BALTIMORE, MARYLAND 21224

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

8. COUNTY

MARYLAND

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

414 S. MACON ST. 21224

5. SEX

MALE

6. RACE

WHITE

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

2-19-92

9. AGE (In years lost birthday)

76

If Under 1 Yr. Months: Days

If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Burner

10B. KIND OF BUSINESS OR INDUSTRY

Steel

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

ROLAND Higgs

14. MOTHER'S MAIDEN NAME

EMILY

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

BCH RECORDS 4940 EASTERN AVE. BALTO. MD. 21224

18.

519.2 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE Due TO, OR AS A CONSEQUENCE OF: Respiratory Failure

15 min

(B) Chronic Obstructive Pulmonary Disease 20 yrs

(C) and Acute Bronchitis with Fever 3 days

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

Arteriosclerotic CV Disease

10 years

19A. DATE OF OPERATION

None

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

No

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) ☐ No

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) none

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

none

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from December 28, 1969 to December 29, 1969, that (I) (we) last saw the deceased alive on December 29, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

DEGREE

Attending Phys. ☐Med. Director ☐Staff Phys. ☒

23B. DATE SIGNED

23C. PHYSICIAN'S NAME (Type)

DR. M. COLMER

23D. ADDRESS

BALTIMORE CITY HOSPITALS

4940 EASTERN AVE. BALTO. MD. 21224

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

1/2/70

24C. NAME OF CEMETERY or CREMATORY

Glen Haven

24D. LOCATION (City, town, or county) (State)

Glen Burnie, Md.

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

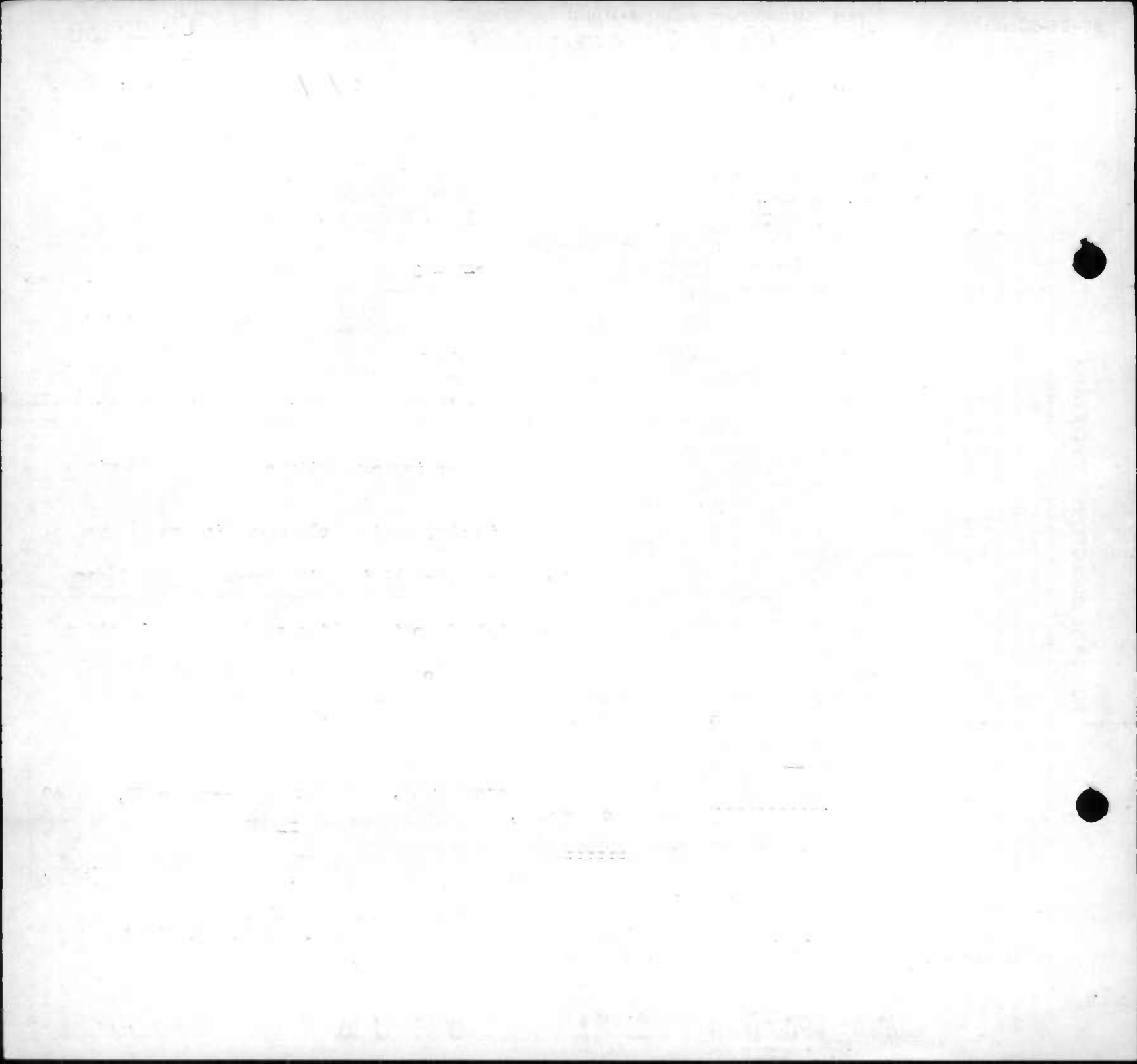
ADDRESS

JAN 5 1970

Ulrich Funeral Home Dundalk, Md.

FUNERAL DIRECTOR: IMPORTANT

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

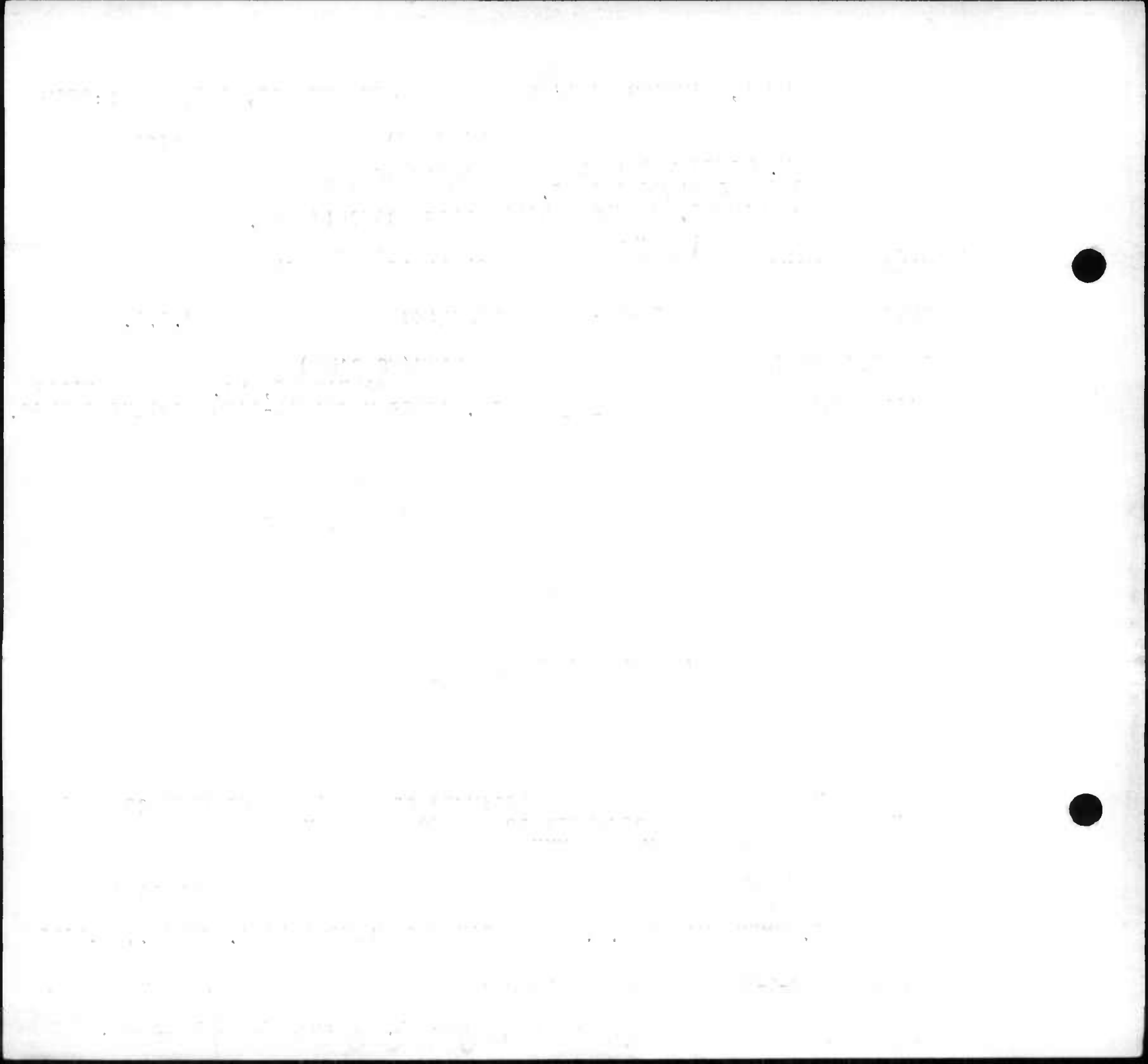
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 13151	
M-200 69 13151		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		DOROTHY M. MEEKS		December 31, 1969 12¹⁰ (4 M.)	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 2413 Washington Blvd. Baltimore, Maryland			A. STATE Maryland		
			B. COUNTY		
C. CITY OR TOWN Baltimore			D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER 2413 Washington Blvd.		
5. SEX Female	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-12-1913	9. AGE (In years last birthday) 56	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John Betzold			14. MOTHER'S MAIDEN NAME Dorothy Feldhaus		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-10-5407	17. INFORMANT ADDRESS Mr. Thomas A. Meeks, 2413 Washington Blvd.		
18. 183.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Gastric Hemorrhage (B) Cranial CA. (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <1 day 1 yr.
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan 12/25 19 69 to Dec 31 19 69 , that (I) (we) last saw the deceased alive on 12/25 19 69 and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Raymond D. Bahr				23B. DATE SIGNED 12/31/69	
23C. PHYSICIAN'S NAME (Type) Raymond D. Bahr		23D. ADDRESS St Agnes Medical Center			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-1-1970		24C. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT. JAN 5 1970		25B. NAME OF REGISTRAR Robert E. Nabey, M.D.		25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229	

[Faint handwritten signature]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>69 13152</u>	
D-140				69 13152	
BIRTH NO.				69 13152	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
DUVAL, MAYNARD WILLIAM			DECEMBER 30, 1969 2:30AM M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
ST. AGNES HOSPITAL CATON & WILKENS AVES. BALTIMORE, MARYLAND 21229			MARYLAND <u>BALTIMORE</u> 21228 <u>5300</u>		
C. CITY OR TOWN			D. INSIDE CITY LIMITS?		
E. STREET AND NUMBER			YES <input type="checkbox"/> NO <input type="checkbox"/>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		
SALESMAN			MARYLAND		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY?		
Lever Bros.			U.S.A.		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
COMPTON DUVAL			MARY (MC CANN)		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
YES WW2			215-10-7909		
17. INFORMANT			ADDRESS		
BALTIMORE, MD.			21229		
ST. AGNES HOSPITAL-CATON & WILKENS AVES.					
18. CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cardiogenic Shock</u>		
			(B) <u>Myocardial Infarction -</u> DUE TO, OR AS A CONSEQUENCE OF:		
			(C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION			20A. AUTOPSY? (Yes or No)		
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			NO		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)			21E. HOW DID INJURY OCCUR?		
21F. HOW DID INJURY OCCUR?					
22. I certify that (X) (this hospital) attended the deceased from <u>DECEMBER 22</u> 19 <u>69</u> to <u>DECEMBER 30</u> 19 <u>69</u> that (X) (we) last saw the deceased alive on <u>DECEMBER 30</u> 19 <u>69</u> and that (X) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE			23B. DATE SIGNED		
			12 30 69		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
S. QUIROZ M.D.			CATON & WILKENS AVES. BALTO., MD. 21229		
24A. BURIAL CREMATION, REMOVAL (Specify)			24B. DATE		
Burial			1-2-1970		
24C. NAME OF CEMETERY or CREMATORY			24D. LOCATION (City, town, or county) (State)		
Meadowridge Cemetery			Washington Blvd. Howard Co. Md.		
25A. DATE REC'D BY HEALTH DEPT.			25B. NAME OF REGISTRAR		
JAN 5 1970			Howard H. Hubbard, 4107 Wilkens Ave. 21229		



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-623		69 13153		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO.		69 13153	
BIRTH NO.				1. NAME OF DECEASED				2. DATE AND HOUR OF DEATH			
				WRIGHT, LILLIAN ELIZABETH ELIZA				DECEMBER 30, 1969 5:30 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)							
FULL NAME OF HOSPITAL OR INSTITUTION				A. STATE				B. COUNTY			
ST AGNES HOSPITAL				MARYLAND				BALTIMORE			
5. SEX				6. RACE				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			
FEMALE				WHITE				WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)			
								MARYLAND			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME				12. CITIZEN OF WHAT COUNTRY?			
MONROE, RICE				CLARA (WOOD)				USA			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service				16. SOCIAL SECURITY NO.				17. INFORMANT			
								RECORD'S BALTIMORE MD 21229			
								ST AGNES HOSPITAL WILKENS & CATON AVE			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:							
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:							
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO, OR AS A CONSEQUENCE OF:							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).											
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)			
								NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED				21F. HOW DID INJURY OCCUR?			
				While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (this hospital) attended the deceased from DECEMBER 29, 1969 to DECEMBER 30, 1969											
that (we) last saw the deceased alive on DECEMBER 30, 1969 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.											
23A. SIGNATURE				23B. DATE SIGNED							
CARLOS ORBEGOSO M.D.				12-30-69							
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE				24C. NAME OF CEMETERY or CREMATORY			
Burial				Jan. 2, 1970				Montgomery Meth.			
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR				25C. FUNERAL DIRECTOR			
JAN 5 1970				JAN 5 1970				3. Molesworth, Damascus, Md.			

Letter from St. Agnes Hospital
2-6-70 M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> 1-263 69 13154 BALTIMORE CITY HEALTH DEPARTMENT </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>		REG. NO. 69 13154	
BIRTH NO. D-263		2. DATE AND HOUR OF DEATH <div style="display: flex; justify-content: space-between;"> 12/26/1969 9:54 PM </div>	
1. NAME OF DECEASED (Type or Print) DI GUARDIO Mrs MAY		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 301	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) CHURCH HOME & HOSPITAL		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 256 DALLAS CT.	
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/5/197
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? Maryland
13. FATHER'S NAME Bess Williams Evans		14. MOTHER'S MAIDEN NAME Rosalie Shirey	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 911184114	17. INFORMANT ADDRESS Rosalie Shirey
18. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. </div> <div style="width: 35%;"> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiac Arrest (B) Myocardial Infarction & Congestive Failure DUE TO, OR AS A CONSEQUENCE OF: Hypertension (C) </div> </div>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/26/69 19 to 12/26/69 19 that (I) (we) last saw the deceased alive on 12/26/69 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE [Signature]		23B. DATE SIGNED 12/26/69	
23C. PHYSICIAN'S NAME (Type) Purcell		23D. ADDRESS MD	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1-5-70	
24C. NAME of CEMETERY or CREMATORY GLEN HAVEN MEM		24D. LOCATION (City, town, or county) (State) GLEN BURNIE, MD.	
25A. DATE REC'D BY HEALTH DEPT. JAN 6 1970		25B. NAME OF REGISTRAR [Signature]	
25C. FUNERAL DIRECTOR Wm. J. Tickner & Sons		ADDRESS BALD. MD.	

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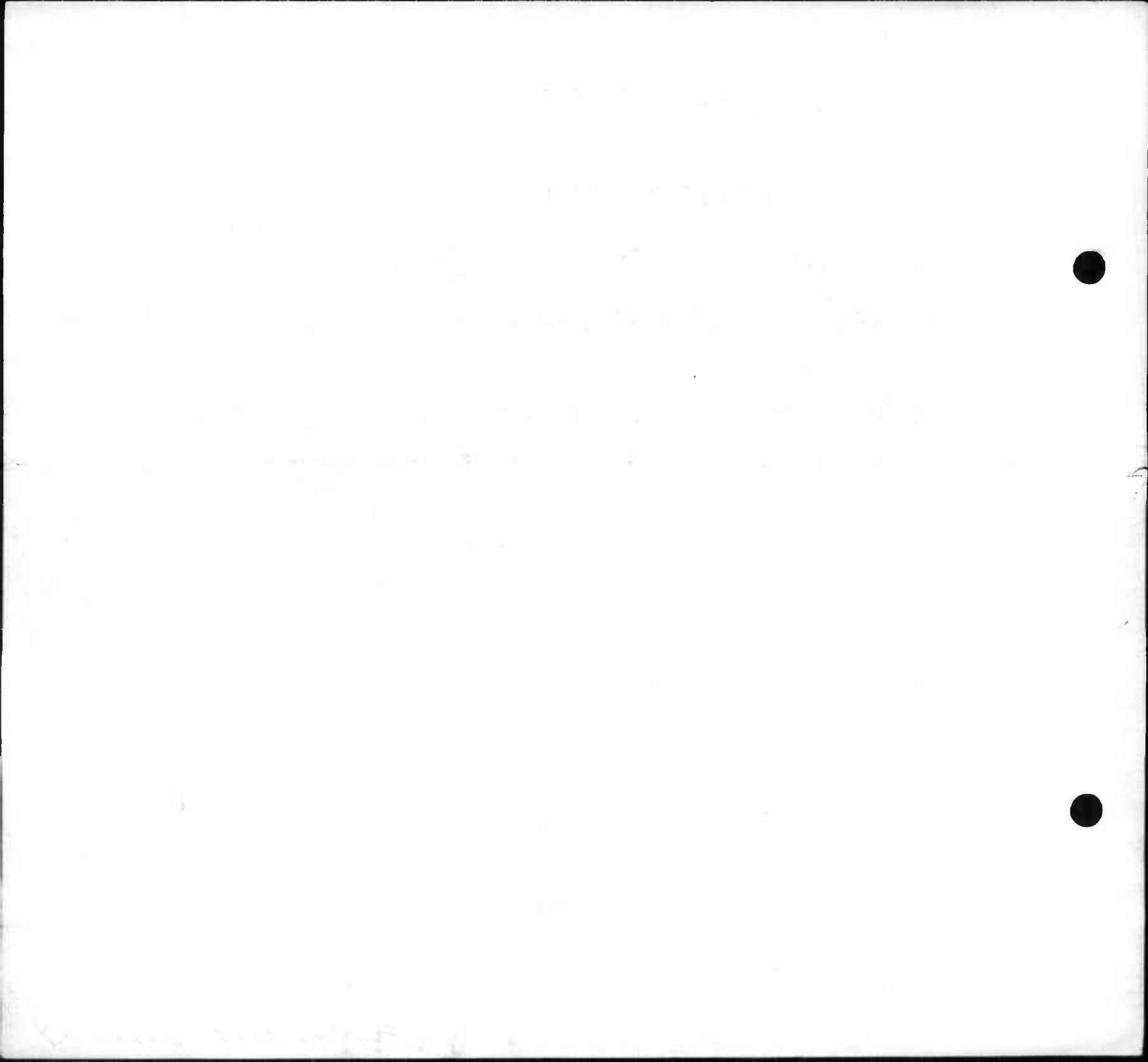
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-416		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 13155	
BIRTH NO.		69 13155		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>ROYCE Eugene Culver</u>		2. DATE AND HOUR OF DEATH <u>12-31-69 @ 4:00 pm</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Wicomico</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>The John Hopkins Hospital</u>		C. CITY OR TOWN <u>Salisbury</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>303 Washington Street</u>					
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>2/23/33</u>	9. AGE (In years last birthday) <u>36</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TEACHER</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>ST. BOARD EDUCATION</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>Glen Culver</u>		14. MOTHER'S MAIDEN NAME <u>Edna L. Whayland</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>220-28-0708</u>		17. INFORMANT <u>GLEN CULVER</u> ADDRESS <u>SEE SEC # 4</u>	
18. <u>582 X I</u> CAUSE OF DEATH—		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>hypotension + cardiac arrest</u>		<u>2 hr</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>retroperitoneal bleeding</u> DUE TO, OR AS A CONSEQUENCE OF:		<u>24 hr</u>	
		(C) <u>chronic renal failure</u>		<u>6-12 mos</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>renal transplant, pulmonary emboli</u>					
19A. DATE OF OPERATION <u>12/23/69 + 12/30</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>renal failure - transplant</u>		20A. AUTOPSY? (Yes or No) <u>no</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>July</u> 19 <u>69</u> to <u>Dec. 31</u> 19 <u>69</u> that (1) (we) last saw the deceased alive on <u>12/31/69</u> 19 <u>69</u> and that (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) not view the body after death.					
23A. SIGNATURE <u>Carole Dorsch, M.D.</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>12/31/69</u>	
23C. PHYSICIAN'S NAME (Type) <u>Carole Dorsch M.D.</u>		23D. ADDRESS <u>Johns Hopkins Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>1/3/1970</u>		24C. NAME OF CEMETERY or CREMATORY <u>Wicomico MEM. PARK</u>	
				24D. LOCATION (City, town, or county) (State) <u>SALISBURY Wico. MD.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 6 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, R.D.</u>		25C. FUNERAL DIRECTOR <u>HALL FUNERAL HOME</u>	
				ADDRESS <u>SALISBURY</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-425		69 13156		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 69 13156	
1. NAME OF DECEASED (Type or Print) <i>Wilson Harry C.</i>				2. DATE AND HOUR OF DEATH <i>Dec. 21, 1969 12:15 P.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <i>35 Church Home & Hospital</i>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>35 Church Home & Hospital</i>				C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>M</i>		6. RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <i>12-11-11</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Carpentry</i>		9. AGE (in years last birthday) <i>58</i>		11. BIRTHPLACE (State or foreign country) <i>Florida</i>	
13. FATHER'S NAME <i>Jack Wilson</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S. A</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>yes II War</i>				16. SOCIAL SECURITY NO. <i>223-20-5468</i>		17. INFORMANT <i>Friend</i>	
18. <i>571.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE <i>Esophageal bleeding</i> DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>	
				(B) <i>Esophageal varices</i> DUE TO, OR AS A CONSEQUENCE OF:			
				(C) <i>Liver cirrhosis</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <i>12-21-69</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>respiratory distress</i>		20A. AUTOPSY? (Yes or No) <i>no</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (qualify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>12-19</i> 19 <i>69</i> to <i>12-21</i> 19 <i>69</i> that (I) (we) last saw the deceased alive on <i>12-21</i> 19 <i>69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>T. H. Lin</i>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>12-21-69</i>	
23C. PHYSICIAN'S NAME (Type) <i>Tsung HER Lin</i>				23D. ADDRESS ANATOMY BOARD OF MARYLAND UNIVERSITY MEDICAL SCHOOL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <i>12-30-69</i>		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City or County) (State)	
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 6 1970</i>		25B. NAME OF REGISTRAR <i>R. E. Taylor, M.D.</i>		25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD		ADDRESS	

Handwritten text, likely bleed-through from the reverse side of the page. The text is extremely faint and illegible due to the quality of the scan. Two punch holes are visible on the right side of the page.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p>B-650 69 13157</p> <p>BALTIMORE CITY HEALTH DEPARTMENT</p> <p>CERTIFICATE OF DEATH</p>		<p>X REG. NO. 69 13157</p>	
<p>BIRTH NO. <u>69-23867</u></p>		<p>2. DATE AND HOUR OF DEATH <u>12-26-69</u> <u>7:45</u> P.M.</p>	
<p>1. NAME OF DECEASED (Type or Print) <u>Baby Roy Brown</u></p>		<p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>5300</u></p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Maryland General Hospital</u> <u>48</u></p>		<p>C. CITY OR TOWN <u>FORT HOWARD</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER <u>14 NORTH POINT Rd.</u></p>	
<p>5. SEX <u>M</u></p>	<p>6. RACE <u>W</u></p>	<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <u>12-26-69</u> 9. AGE (In years last birthday) <u>Newborn</u></p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p>		<p>10B. KIND OF BUSINESS OR INDUSTRY</p>	
<p>11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u></p>		<p>12. CITIZEN OF WHAT COUNTRY <u>USA</u></p>	
<p>13. FATHER'S NAME <u>Richard Brown</u></p>		<p>14. MOTHER'S MAIDEN NAME <u>Kathleen Schuster-Sawyer</u></p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p>		<p>16. SOCIAL SECURITY NO.</p>	
<p>17. INFORMANT</p>		<p>ADDRESS</p>	
<p>18. <u>777 X I</u> CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p>(A) IMMEDIATE CAUSE <u>Unknown</u> DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(B) <u>Premature baby 3 Lb 6 Oz</u> DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) _____</p> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p>			
<p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>			
<p>19A. DATE OF OPERATION <u>D</u></p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	
<p>20A. AUTOPSY? (Yes or No) <u>No</u></p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)</p>	
<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE <u>M. W. Lee MD</u></p>		<p>23B. DATE SIGNED</p>	
<p>23C. PHYSICIAN'S NAME (Type)</p>		<p>23D. ADDRESS</p>	
<p>ANATOMY BOARD OF MARYLAND</p> <p>JOHNS HOPKINS MEDICAL SCHOOL</p>			
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <u>1-5-70</u></p>		<p>24B. DATE</p>	
<p>24C. NAME OF CEMETERY OR CREMATORY</p>		<p>24D. LOCATION (City, town, county) (State)</p>	
<p>25A. DATE REC'D BY HEALTH DEPT. <u>JAN 6 1970</u></p>		<p>25B. NAME OF REGISTRAR <u>Robert E. Kelly</u></p>	
<p>25C. FUNERAL DIRECTOR</p>		<p>25D. PRESS</p>	
<p>MORTUARY SERVICE - BCHD</p>			

Bobt Boy Brown

1 Hazelton

12-26-09

Ward Lane

BoHo

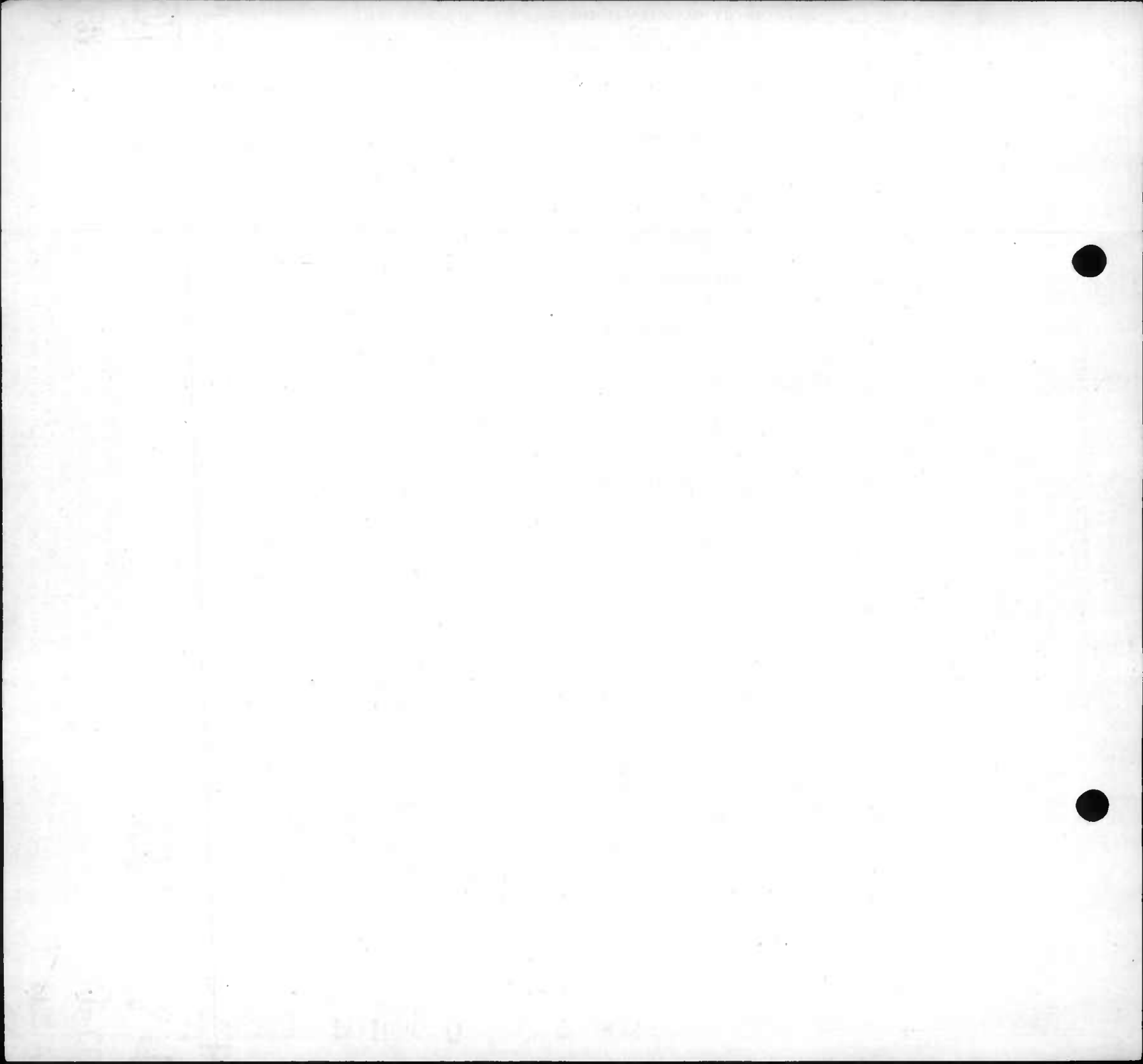
Ward Lane

2 30

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

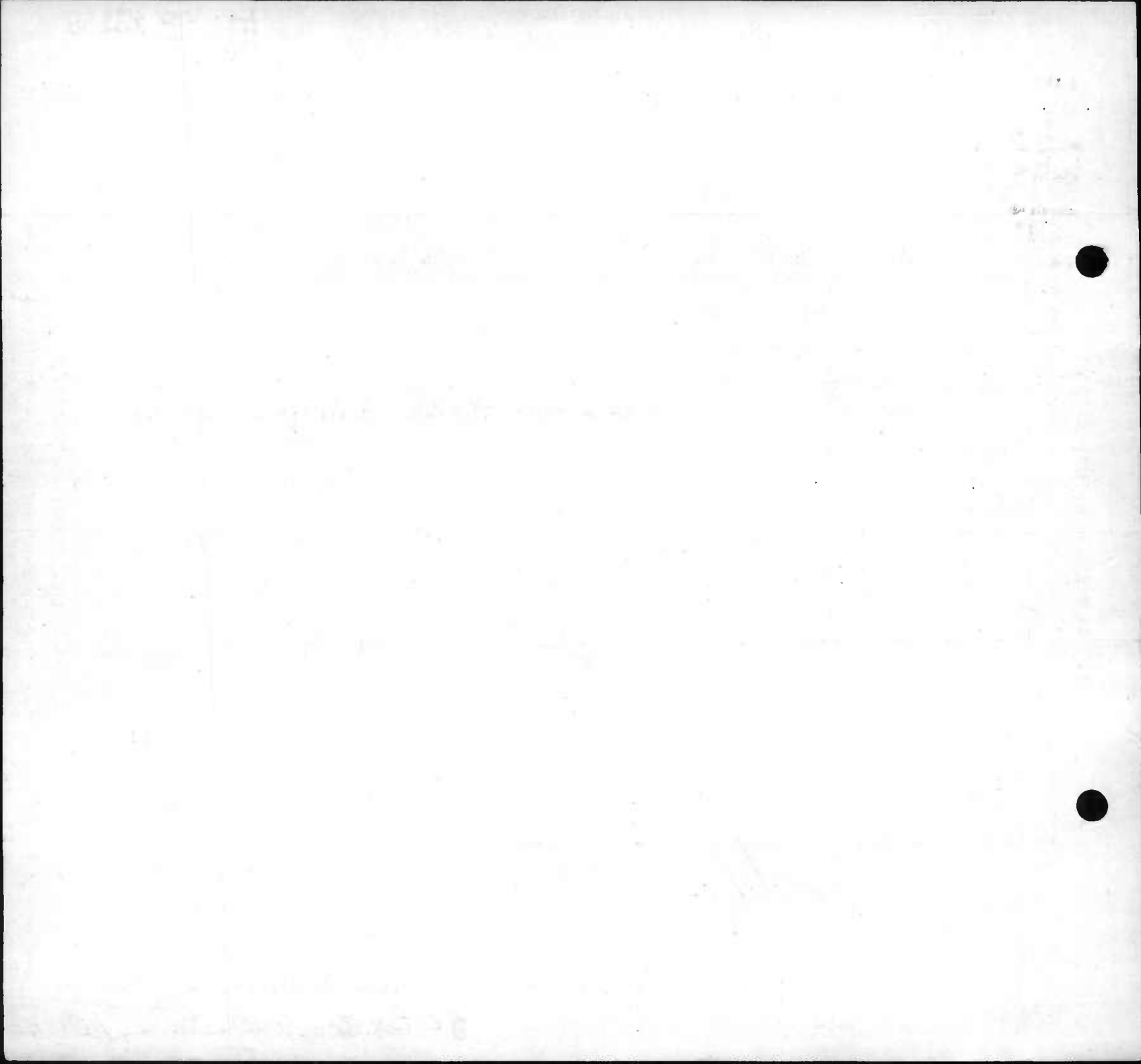
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 13158
BIRTH NO. D-120 69.24393		CERTIFICATE OF DEATH 69 13158		
1. NAME OF DECEASED (Type or Print) BABY GIRL DAVIS		2. DATE AND HOUR OF DEATH 12-27-69 4.20 P.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) THE JOHNS HOPKINS HOSPITAL 33		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE CITY C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 125 COLVIN STREET		
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-27-69	9. AGE (In years lost birthday) 5 20
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME SHIRLEY DAVIS		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
18. CAUSE OF DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				
(A) IMMEDIATE CAUSE CARDIORESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF: 20 MIN				
(B) INTRACRANIAL BLEED DUE TO, OR AS A CONSEQUENCE OF: LIFETIME				
(C) CONGENITAL SYPHILIS DUE TO, OR AS A CONSEQUENCE OF: 11				
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). PREMATURITY				
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (H) (this hospital) attended the deceased from DEC 27 1969 to DEC 27 1969 , that (H) (we) last saw the deceased alive on DEC 27 1969 and that in (H) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.				
23A. SIGNATURE G.R. Greene MD				23B. DATE SIGNED 12/27/69
23C. PHYSICIAN'S NAME (Type) G.R. GREENE		23D. ADDRESS THE JOHNS HOPKINS HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 12/29/69		24C. NAME OF CEMETERY OR CREMATORY Johns Hopkins Hospital 601 N. Broadway Balto., Md.
25A. DATE REC'D BY HEALTH DEPT. JAN 6 1970		25B. NAME OF REGISTRAR Robert E. Baker, MD		25C. FUNERAL DIRECTOR HOSPITAL DISPOSAL



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

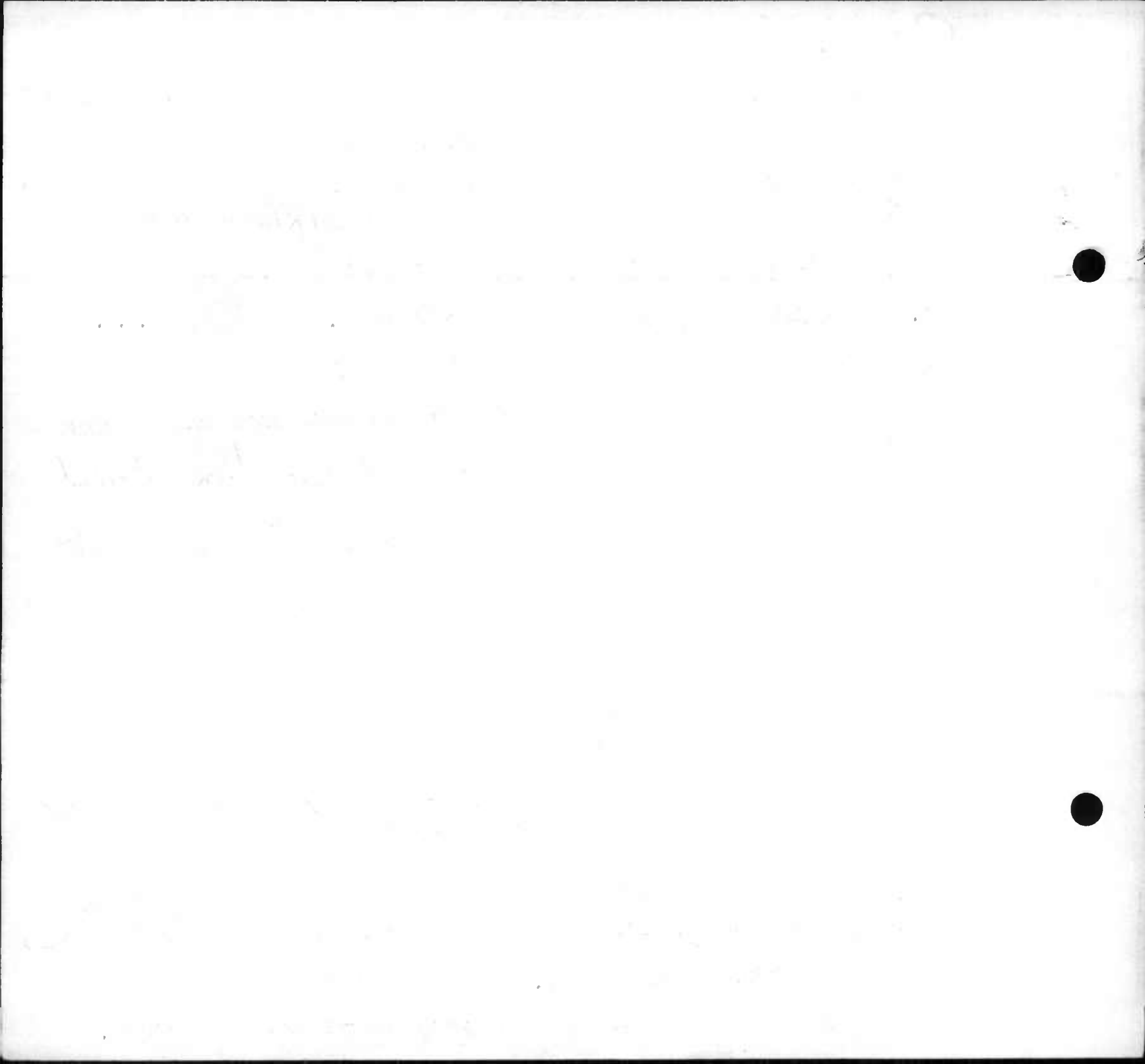
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 69 13159	
W-410 69 13159		BIRTH NO.		DATE AND HOUR OF DEATH		12/31/69 2 ⁰⁰ AM M.	
1. NAME OF DECEASED (Type or Print) KELLEN WOLFE				2. DATE AND HOUR OF DEATH			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 337 JMS Hopkins				A. STATE MD.		B. COUNTY Frederick	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN Woodsboro		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER RT 1 21798							
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/14/03	9. AGE (In years last birthday) 66	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Andrew J. Wolfe			14. MOTHER'S MAIDEN NAME Blanche M. Baker				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 214-16-0238		17. INFORMANT Mrs Keller A. Wolfe, Woodsboro RI md.		
18. CAUSE OF DEATH 450X H DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Pulmonary Embolus			19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Systemic Nocardiosis, Cryptococcal meningitis			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (H) (this hospital) attended the deceased from 12/13/69 19 69 to 12/31 19 69 , that (H) (we) last saw the deceased alive on 12/31 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.							
23A. SIGNATURE John A. Stobo				23B. DATE SIGNED 12/31/69		23C. PHYSICIAN'S NAME (Type) John A. Stobo, M.D.	
23D. ADDRESS The Johns Hopkins Hospital							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/3/70		24C. NAME OF CEMETERY or CREMATORY Resthaven Memorial Gardens		24D. LOCATION (City, town, or county) (State) Mt. Vernon, Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 6 1970		25B. NAME OF REGISTRAR John E. Stobo		25C. FUNERAL DIRECTOR W. C. Barton, Walkersville, Md.		ADDRESS 21793	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-000		69 13160		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		X REG. NO. 69 13160	
1. NAME OF DECEASED (Type or Print) Cohee, Florence				2. DATE AND HOUR OF DEATH December 31, 1969 12:15 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) House in The Pines - Bel Air				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Balto. Co. C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2020 Oakland Ave.			
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-5-1894	9. AGE (In years last birthday) 75	10. Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Receptionist		10B. KIND OF BUSINESS OR INDUSTRY Doctors Office		11. BIRTHPLACE (State or foreign country) Baltimore Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Roberts				14. MOTHER'S MAIDEN NAME Lillie Della			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-32-9434A		17. INFORMANT Mrs Sherman Harris White Marsh		ADDRESS Md 21262	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 410.941 250.9 Myocardial infarction DISEASE OR CONDITION GIVEN IN PART I (A). Anterior division, general DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Diabetes mellitus				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 yrs			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Oct 1969 to Dec 30 1969 that (I) (we) last saw the deceased alive on Dec 30 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Louis Semenovoff				23B. DATE SIGNED 12/31/69			
23C. PHYSICIAN'S NAME (Type) LOUIS SEMENOFF				23D. ADDRESS 2108 CRENS RD BALTO MD 21220			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/3/70		24C. NAME OF CEMETERY or CREMATORY Parkwood Cem.		24D. LOCATION (City, town, or county) (State) Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT. JAN 6 1970		25B. NAME OF REGISTRAR John E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS Lassahn Funeral Home 7401 Belair Rd.			



5-143

69 13161

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 13161

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) CHARLES SPAULDING		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1 W. 27th St.		3. DATE PRONOUNCED DEAD Month Day Year Hour 12 28 69 1:15 P.M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 76		10. AGE (In years last birthday) 76	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. 212016511A	
18. INFORMANT		ADDRESS	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Russell S. Fisher, M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		DATE SIGNED 12-29-69	
24A. BURIAL-CREATION, REMOVAL (Specify) BURIAL		24B. DATE JAN 5 1970	
24C. NAME OF CEMETERY or CREMATORY MT. OLIVET CEM.		24D. LOCATION (City, town, or county) (State) BALTO. MD.	
25A. DATE RECEIVED BY HEALTH DEPT. JAN 6 1970		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Wm. J. TUCKNER		ADDRESS BALTO. MD.	

1918

RECEIVED

ACADEMY ROOM

[Handwritten signature]

1918

69 13162 BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 69 13162

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Oliver Bearman (BEAMON) 2. DATE OF DEATH Known ☒ Estimated ☐ Month Day Year Hour
3. DATE PRONOUNCED DEAD Month Day Year Hour
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
6. SEX male 7. RACE colored 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 9. DATE OF BIRTH 10. AGE (in years last birthday) 70 11. BIRTHPLACE (State or foreign country) VIRGINIA 12. CITIZEN OF WHAT COUNTRY? 13. FATHER'S NAME JOHN BEAMON 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 14B. KIND OF BUSINESS OR INDUSTRY 15. MOTHER'S MAIDEN NAME NETTIE 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) 17. SOCIAL SECURITY NO. 18. INFORMANT ADDRESS MARY L. STRONG 228 DOUGLAS CT. 19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Arteriosclerotic cardiovascular disease (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED 21. AUTOPSY? (Yes or No) Partial 22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR? 22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 22E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 22F. HOW DID INJURY OCCUR? 23. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ ACTUAL SIGNATURE Werner U. Spitz M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ ASSOCIATE MEDICAL EXAMINER ☐ DATE SIGNED 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL 24B. DATE 12/31/69 24C. NAME OF CEMETERY OR CREMATORY MT HUBURN 24D. LOCATION (City, town, or county) (State) BALTO, MD. 25A. DATE REC'D BY HEALTH DEPT. JAN 6 1970 25B. NAME OF REGISTRAR Robert E. [unclear] 25C. FUNERAL DIRECTOR ADDRESS E. O. Wilson 1000 BRANTLEY AVE

MENTAL EXAMINATION REPORT

DATE: 10/10/1964
PATIENT: JAMES EARL RAY
CLINICAL HISTORY: [Faint text describing patient history and symptoms]

PHYSICAL EXAMINATION: [Faint text describing physical exam findings]

PSYCHOLOGICAL TESTS: [Faint text describing psychological test results]

DIAGNOSIS: [Faint text describing the diagnosis]

RECOMMENDATIONS: [Faint text describing treatment recommendations]

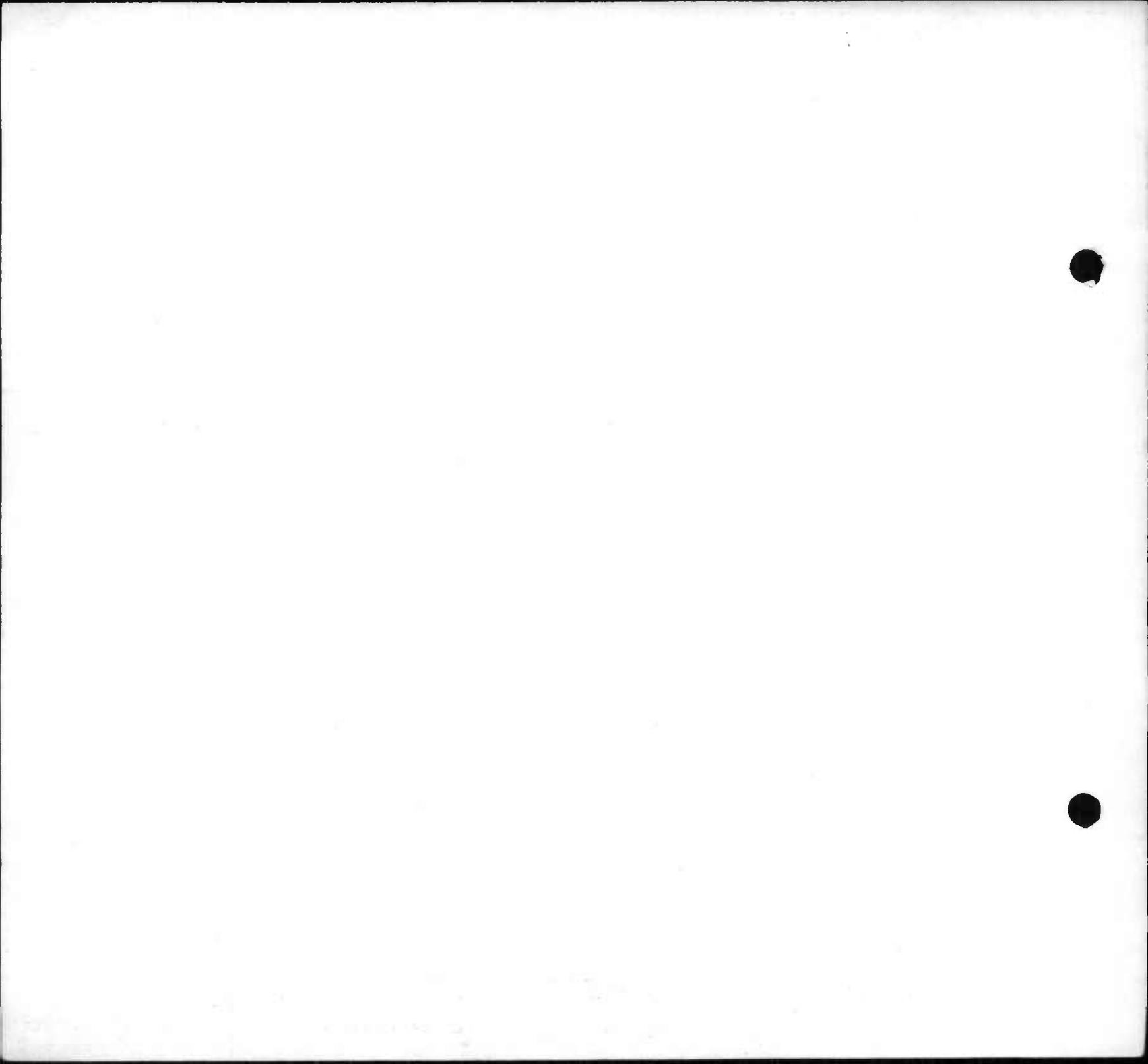
Signature: [Faint signature]

ACAD 11111 BOPB

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-424		69 13163		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 13163	
CERTIFICATE OF DEATH							
1. NAME OF DECEASED (Type or Print) <i>Eva Marie Whelchel</i>				2. DATE AND HOUR OF DEATH <i>12-31-69</i> <i>3 25 A. M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>University Hospital</i>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>625 N. Carrollton Ave.</i>			
5. SEX <i>F</i>	6. RACE <i>N</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>12/4/04</i>	9. AGE (In years last birthday) <i>65</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Md.</i>	
13. FATHER'S NAME <i>William Henry</i>				14. MOTHER'S MAIDEN NAME <i>Daisy Pinkard</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>214-20-1740</i>		17. INFORMANT <i>James Whelchel Son</i>	
18. <i>436.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				(A) IMMEDIATE CAUSE <i>Cardiopulmonary Arrest</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>Probable CVA</i> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>45 min.</i>	
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>Dec. 30</i> 19 <i>69</i> to <i>Dec. 31</i> 19 <i>69</i> that (I) (we) last saw the deceased alive on <i>Dec. 31</i> 19 <i>69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Richard J. O'Brien, MD</i>				23B. DATE SIGNED <i>12-31-69</i>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) <i>Richard J. O'Brien, MD</i>				23D. ADDRESS <i>University Hospital</i>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>1/5/70</i>		24C. NAME OF CEMETERY or CREMATORY <i>Harvey Green</i>		24D. LOCATION (City, town, or county) (State) <i>Arundel Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 6 1970</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>E.O. Wilson</i>		ADDRESS <i>1000 BRANTLEY AVE</i>	



B-460 69 13164

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 13164

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) MARY BAYLOR				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hospital (DOA)				3. DATE PRONOUNCED DEAD Month Day Year Hour 12 28 69 5:48 P.M.			
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 1002							
6. SEX Female	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH June 10 1926		10. AGE (In years last birthday) 43		E. STREET AND NUMBER 718 N. Eden St.			
11. BIRTHPLACE (State or foreign country) Baltimore Md.		12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME James Baylor			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Louise Baylor			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO.		18. INFORMANT Bernice Harington		ADDRESS 11 Cottage Ave	
19. 480 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Fatty liver				CAUSE OF DEATH Lobar pneumonia (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Russell S. Fisher, M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 12-29-69 EXAMINER'S NAME (Type) ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-2-70		24C. NAME OF CEMETERY or CREMATORY Mt Auburn Cem		24D. LOCATION (City, town, or county) (State) Balt Md	
25A. DATE REC'D BY HEALTH DEPT. JAN 6 1970		25B. NAME OF REGISTRAR Robert S. Fisher, Jr.		25C. FUNERAL DIRECTOR Chas. W. H. 1000 Brantley St.		ADDRESS	

ACADEMIC RECORD

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-200		69 13165		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 69 13165	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <u>COOK, SAMUEL J.</u>				2. DATE AND HOUR OF DEATH <u>12/31/69</u> <u>2 30 P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>604</u>				C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>CHURCH HOME & Hospital</u> <u>Broadway & Fayette St.</u>				E. STREET AND NUMBER <u>13 N. DURHAM Street</u>					
5. SEX <u>M</u>	6. RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT 3, 1896</u>		9. AGE (in years last birthday) <u>73 yrs</u>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>UNK</u>				14. MOTHER'S MAIDEN NAME <u>UNK</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>EMMA COOK (WIDOW)</u> ADDRESS <u>S/A</u>			
18. <u>486 Y I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH I (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
				(A) IMMEDIATE CAUSE <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF: <u>?</u>					
				(B) <u>Pneumonia & chronic lung disease for weeks</u> DUE TO, OR AS A CONSEQUENCE OF: <u>?</u>					
				(C) <u>Chronic renal failure; Polydipsia</u> DUE TO, OR AS A CONSEQUENCE OF: <u>?</u>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>12-28</u> 19 <u>69</u> to <u>12-31</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>12-31</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Rodelio M. Lim</u>				DEGREE <u>Attending Phys.</u>		Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>12-31-69</u>	
23C. PHYSICIAN'S NAME (Typo) <u>RODELIO M. Lim</u>				23D. ADDRESS <u>Church Home & Hosp.</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>1/5/70</u>		24C. NAME OF CEMETERY or CREMATORY <u>MOUNT AUBURN</u>		24D. LOCATION (City, town, or county) (State) <u>BALTO, Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 6 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>E. P. WILSON</u>		ADDRESS <u>1000 BRANTLEY AVE</u>			

69 13166

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 13166

BIRTH NO.

1. NAME OF DECEASED (Type or Print) DOUGLAS GREEN				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> Month Day Year Hour M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1900 Penrose Avenue				3. DATE PRONOUNCED DEAD Month Day Year Hour December 31, 1969 4:30 A.M.			
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2001							
6. SEX Male	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH May 5 - 1899		10. AGE (In years last birthday) 70	11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME BOB GREEN		14. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Retired		15. MOTHER'S MAIDEN NAME ELIZA PATRICK			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) YES		17. SOCIAL SECURITY NO. 212-05-3309		18. INFORMANT CHANEY E. GREEN		ADDRESS S/A	
19. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) no	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 12/31/69 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>							
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1/5/70		24C. NAME OF CEMETERY or CREMATORY BALTO NATL CEM		24D. LOCATION (City, town, or county) (State) BALTO MD.	
25A. DATE REC'D BY HEALTH DEPT. JAN 6 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR E.O. WILSON		ADDRESS 1000 BRANTLEY AVE.	

NAME		DATE	
SEX		AGE	
RACE		OCCUPATION	
RESIDENCE		PLACE OF BIRTH	
EDUCATION		MILITARY SERVICE	
MARITAL STATUS		RELIGION	
PREVIOUS INJURIES		PREVIOUS ILLNESSES	
PRESENT ILLNESSES		PHYSICAL EXAMINATION	
MENTAL EXAMINATION		CONCLUSION	
SIGNATURE OF PHYSICIAN		DATE	
SIGNATURE OF PATIENT		DATE	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-553 BIRTH NO. 69 13167		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 69 13167	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) MRS ETHEL R. HAMMOND			2. DATE AND HOUR OF DEATH 12 / 30 / 1969 9.35 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 48 MARYLAND GEN. Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 2201 CALLOW Ave. Md 21217		
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 7/7/1914	9. AGE (In years last birthday) 55	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. 12. CITIZEN OF WHAT COUNTRY? U.S.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10B. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Md.	
13. FATHER'S NAME Rufus Biggs			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT CHART,	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) 571.841.250.9 Cirrhosis, nutritional type exacerbating Sepsis Salmonellosis years			CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH II		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Rheumatic H. Disease, Cirrhosis, Diabetes mellitus.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/26/1969 to 12/30/1969 , that (I) (we) last saw the deceased alive on 12/30/1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Mohamed S. Ibrahim M.D.				23B. DATE SIGNED 12/30/69	
23C. PHYSICIAN'S NAME (Type) M. S. AL-IBRAHIM M.D.				23D. ADDRESS Md Gen Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1/3/70		24C. NAME OF CEMETERY or CREMATORY Cooksville	
		24D. LOCATION (City, town, or county) (State) Maryland			
25A. DATE REC'D BY HEALTH DEPT. JAN 6 1970			25B. NAME OF REGISTRAR Adolphus Halstead		
			25C. FUNERAL DIRECTOR ADDRESS 1206 W north Ave		

Caribbean, Central and South

Spain

10

254

G-650 69 13168 BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. **69 13168**

BIRTH NO.		1. NAME OF DECEASED (Type or Print) JOHN THOMAS GORHAM		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
39 99		4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION PROVIDENT HOSPITAL (DOA) (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year Hour December 30, 1969 8:50 P. M.	
6. SEX Male		7. RACE Negro		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 8-16-1918		10. AGE (In years last birthday) 51		11. BIRTHPLACE (State or foreign country) Falkland, North Carolina	
12. CITIZEN OF U.S.A.		13. FATHER'S NAME James Gorham, Sr.		14. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1604	
15. MOTHER'S MAIDEN NAME Maggie Cherry		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes 2/12/42 11/27/45		17. SOCIAL SECURITY NO. 212-18-3731	
18. INFORMANT Mrs. Maria T. Gorham		19. ADDRESS 1831 W. Lanvale St.		20. CAUSE OF DEATH Gunshot wound of chest	
21. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		22. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		23. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
24. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		25. MEDICAL CERTIFICATION		26. II	
27. 20A. DATE OF OPERATION 2		28. 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		29. 21. AUTOPSY? (Yes or No) yes	
30. 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		31. 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Store		32. 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Fonte's Liq. Store-1202 W. North Avenue 1303	
33. 22D. TIME (Month) (Day) (Year) (Hour) (Approx.) 12-30-69 8:22 P.		34. 22E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		35. 22F. HOW DID INJURY OCCUR? Shot during attempted holdup	
36. 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>		37. ACTUAL SIGNATURE Ronald N. Kornblum, M.D.		38. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
39. 24A. BURIAL CREMATION, REMOVAL (Specify) Burial		40. 24B. DATE 1-5-70		41. 24C. NAME OF CEMETERY OR CREMATORY Baltimore Nat'l Cem.	
42. 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		43. 25A. DATE REC'D BY HEALTH DEPT. JAN 6 1970		44. 25B. NAME OF REGISTRAR Robert E. Taylor, R.D.	
45. 25C. FUNERAL DIRECTOR MORTON & DYETT F.H.		46. 25D. ADDRESS 1701 Laurens St.		47. VS 151-REV. 7/1/68	

4825.119690010154

ACADEMIC RECORD

WILLIAM C. BROWN

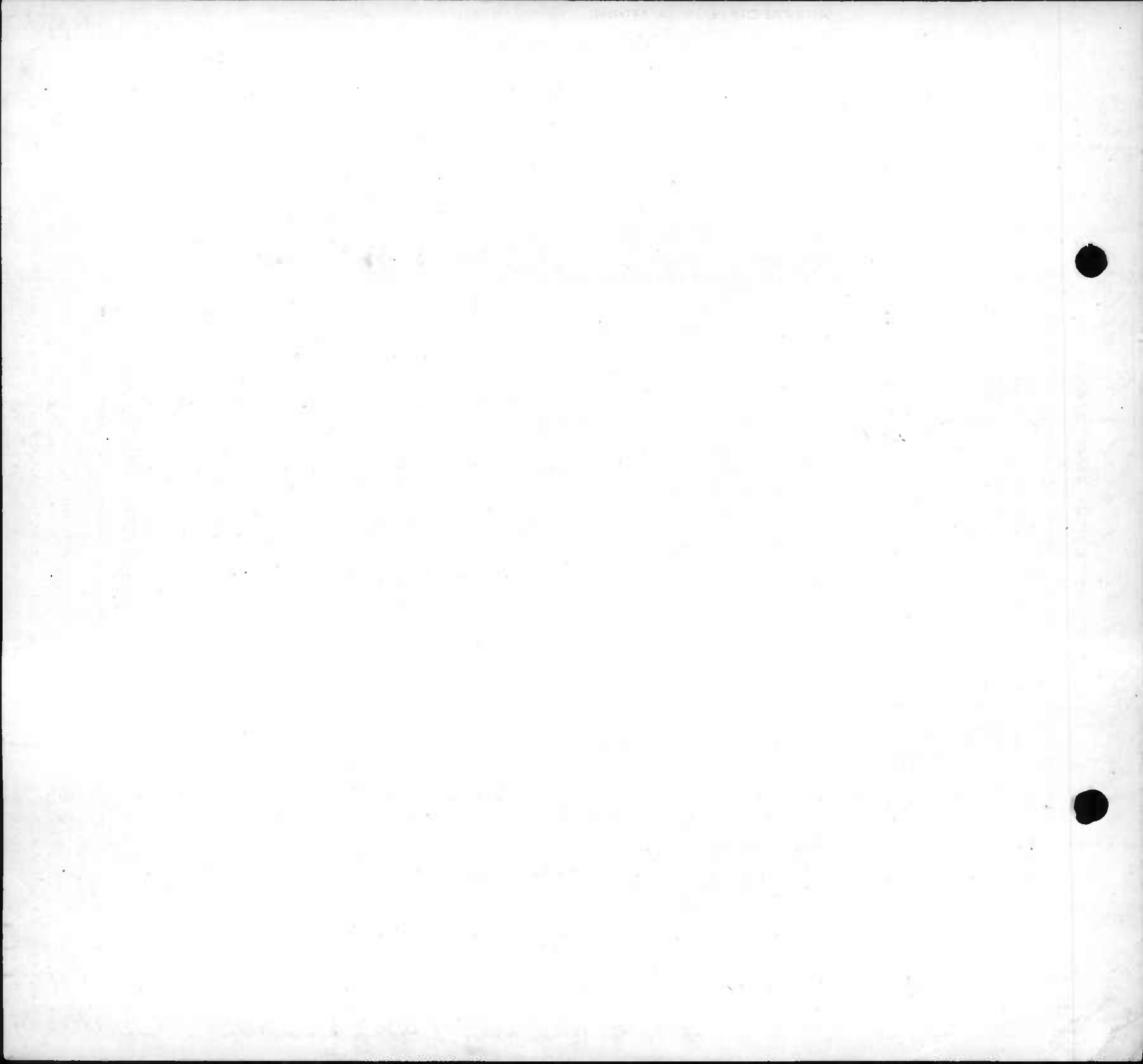
U.S. 61

Released. Now med. Mr. Kornblom.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>H-252</u>				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>69 13169</u>	
1. NAME OF DECEASED (Type or Print) <u>ANNIE HUGGINS</u>				2. DATE AND HOUR OF DEATH <u>Dec. 31, 1969</u> <u>3:45</u> A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>33 JOHNS HOPKINS HOSPITAL</u>				A. STATE <u>MARYLAND</u>		B. COUNTY <u>704</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>811 W. DALLAS ST.</u>			
5. SEX <u>FEMALE</u>	6. RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 10, 1902</u>	9. AGE (In years last birth) <u>67</u>	10. Under 1 Yr. Months: Days: Hours: Min.		11. Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Midway, South Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>UNK</u>			14. MOTHER'S MAIDEN NAME <u>UNK</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No.</u>			16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr. Clarence Rice</u>		
					ADDRESS <u>2625 Robb St.</u>		
18. <u>4-12-2-1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oslhenia, etc. It means the disease, injury or complication which caused death.) <u>ASPIRATION PNEUMONITIS</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>CEREBROVASCULAR ACCIDENT</u>				DUE TO, OR AS A CONSEQUENCE OF: <u>4 days</u>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>II</u>				DUE TO, OR AS A CONSEQUENCE OF: <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u> <u>many years</u>			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <u>Dec. 31</u> <u>1969</u> to <u>Dec. 31</u> <u>1969</u> , that (1) (we) last saw the deceased alive on <u>Dec. 31</u> <u>1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Stephen E. Achuff</u> M.D.				23B. DATE SIGNED <u>Dec. 31, 1969</u>		23C. PHYSICIAN'S NAME (Type) <u>Stephen Achuff, M.D.</u>	
23D. ADDRESS <u>The Johns Hopkins Hospital</u>							
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>1/5/70</u>		24C. NAME of CEMETERY or CREMATORY <u>Mt. Calvary Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>A.A. Co., Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 6 1970</u>		25B. NAME OF REGISTRAR <u>John E. Schaff</u>		25C. FUNERAL DIRECTOR <u>Morton & Dyett F.H.</u>		ADDRESS <u>1701 Laurens St.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

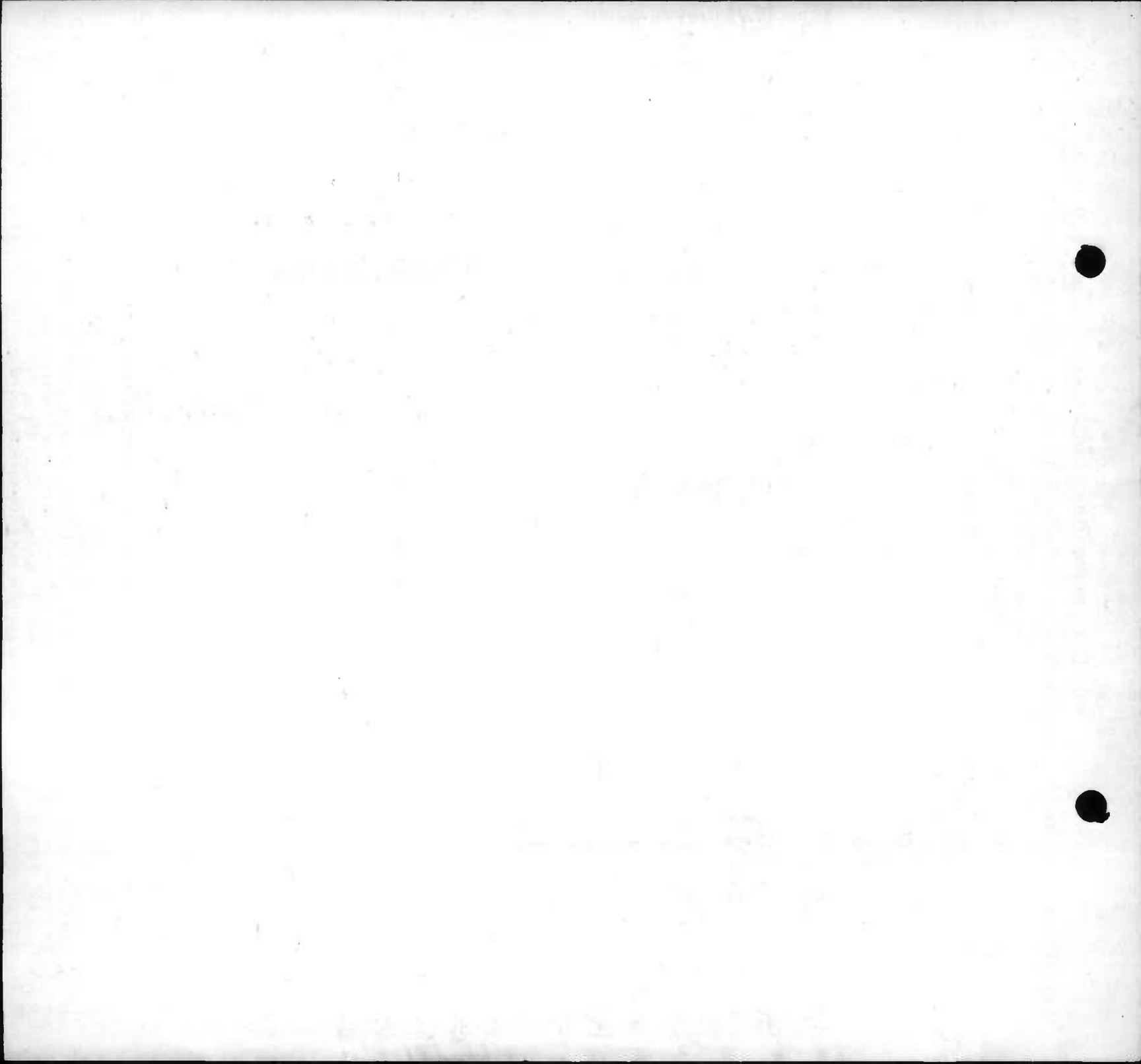
136 15 25 RS M-216

69 13170

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 69 13170

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Joe McIVER</u>		2. DATE AND HOUR OF DEATH <u>12/30/69</u> <u>6 00 PM</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1001</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>33 Johns Hopkins Hospital</u>			C. CITY OR TOWN <u>BALTIMORE,</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <u>1201 N. EDEN ST.</u>		
5. SEX <u>MALE</u>	6. RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-16-1934</u>	9. AGE (In years last birthday) <u>45</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>N.C.</u>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <u>John McIVER</u>		14. MOTHER'S MAIDEN NAME <u>Mary Hooker</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <u>Mary McLean, Washington D.C.</u>		
18. <u>431.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>INTRACRANIAL HEMORRHAGE</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>HYPERTENSION</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u> <u>2 hrs</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>XXXX NO</u>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from <u>12/29</u> 19 <u>69</u> to <u>12/30</u> 19 <u>69</u> , that (H) (we) last saw the deceased alive on <u>12/30</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>John H Stobo</u>				23B. DATE SIGNED <u>12/30/69</u>	
23C. PHYSICIAN'S NAME (Type) <u>JOHN H STOBO</u>				23D. ADDRESS <u>THE JOHNS HOPKINS HOSPITAL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-3-70</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt Auburn Cem Balto Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 6 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Raymond Sanders</u>	
				ADDRESS <u>517 E. Preston St</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-152		69 13171		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 13171	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) Robert James Bivens			
2. DATE AND HOUR OF DEATH 31 Dec..69				7:30 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 John's Hopkins Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1001 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1321 E. Biddle St.			
5. SEX M	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Feb. 15, 1915		9. AGE (In years last birthday) 54	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10B. KIND OF BUSINESS OR INDUSTRY MAINTENANCE		11. BIRTHPLACE (State or foreign country) Chance Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME John Columbus Bivens				14. MOTHER'S MAIDEN NAME Edith Hull			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 212-10-1263		17. INFORMANT ADDRESS Martin DaShields 124 N. Mt. Olivet Ln.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 4/10/9 I CORONARY OCCLUSION? ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerotic Heart Disease? II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C).....			
19A. DATE OF OPERATION 0				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Dec 15 1969 to Dec 31 1969, that (I) (we) last saw the deceased alive on Dec 20 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.							
23A. SIGNATURE F. K. Adams				23B. DATE SIGNED 1-3-70		23C. PHYSICIAN'S NAME (Type) F. K. ADAMS	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL				24B. DATE 1/5/70		24C. NAME OF CEMETERY OR CREMATORY ST CHARLES	
25A. DATE REC'D BY HEALTH DEPT. JAN 6 1970				25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Leroy Webster Princes Anne Md	

1891. 12. 12

Internal Revenue Service
General Excise Tax

10

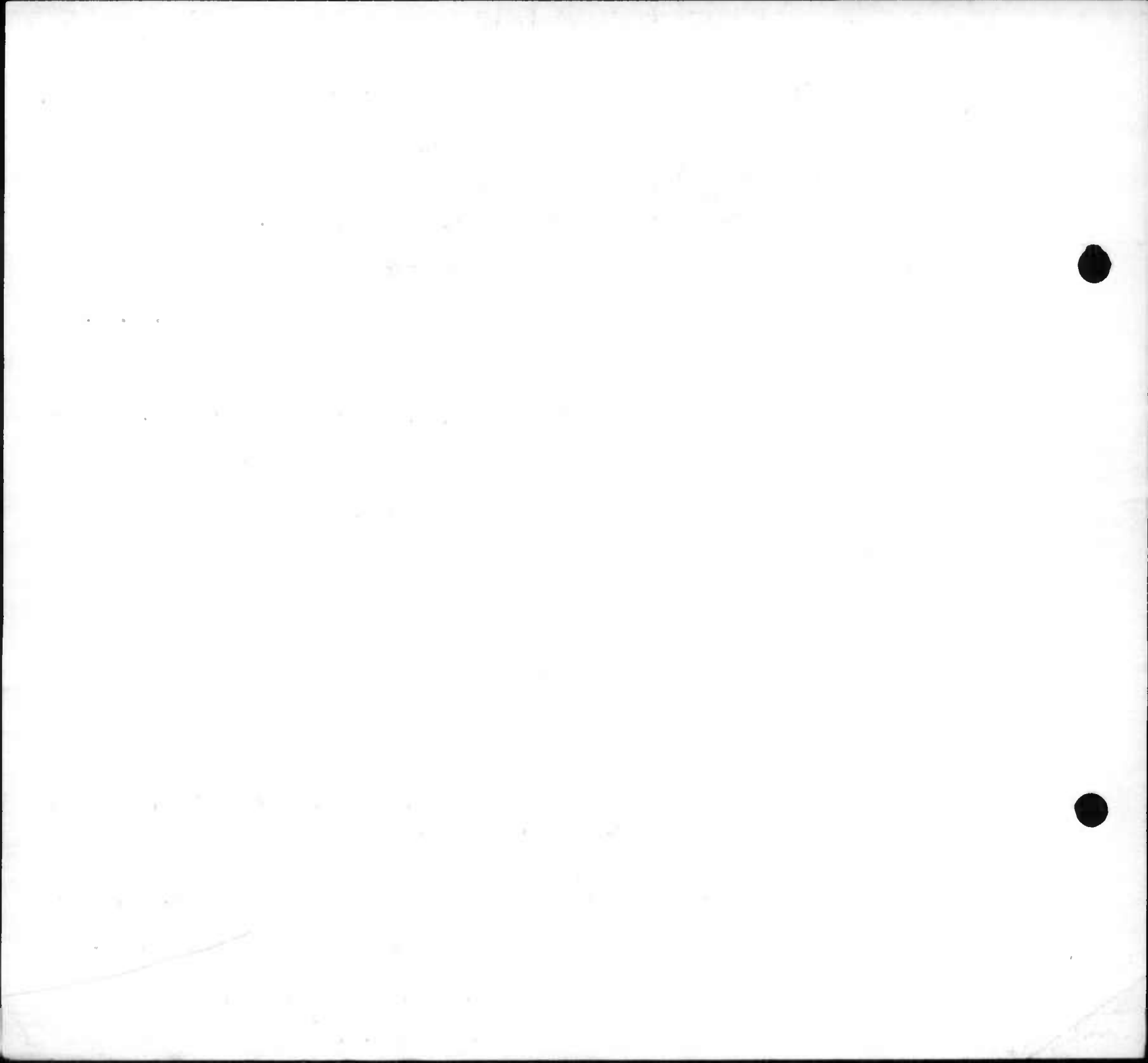
Dec 12 1891

1555 N. Green St
Chicago, Ill.

J. A. Adams

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-320 69 13172		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 13172	
CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Watts, Anita		2. DATE AND HOUR OF DEATH 12-31-69 12:00 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1402	
FULL NAME OF HOSPITAL OR INSTITUTION 39		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Provident Hospital 1514 Divison Street Baltimore, Maryland 21217		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Female		6. RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 08-29-98	
13. FATHER'S NAME Charles Sparrow		14. MOTHER'S MAIDEN NAME		9. AGE (In years last birthday) 71	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. 216-07-9323		11. BIRTHPLACE (State or foreign country) Maryland	
17. INFORMANT Mrs. F. Harmond		ADDRESS 859 Vine St. Da.-in-Law		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ASCVD with CHF (Congestive Heart Failure)					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from December 26, 19 69 to December 31, 19 69 that (I) (we) last saw the deceased alive on December 31, 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. C. Laredo M.D.				23B. DATE SIGNED Dec. 31, 1969	
23C. PHYSICIAN'S NAME (Type) C. LAREDO M.D.		23D. ADDRESS 1514 Divison Street Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-5-70		24C. NAME OF CEMETERY or CREMATORY Baltimore Nat'l. Cem.	
24D. LOCATION Balto. Md.		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. JAN 6 1970		25B. NAME OF REGISTRAR V. Bailey		25C. FUNERAL DIRECTOR V. Bailey	
25D. ADDRESS 1348 Calhoun Street		25E. ADDRESS			



T-614

69 13173

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 13173

REG. NO.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

GILBERT TRIPLETTI

2. DATE
OF
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

12

12

69 11:15 a.m.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
OR INSTITUTION)

Maryland General Hospital D.O.A.

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

Dec.

12,

1969 11:15 a.m.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

Balto.

YES ☐ NO ☐

6. SEX

Male

7. RACE

White

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. DATE OF BIRTH

10. AGE (In years
last birthday)

59

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

205 E. Preston St.

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

19.

303.9 I

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) IMMEDIATE CAUSE Acute alcoholism
DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

Arteriosclerotic cardiovascular disease

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

YES

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.)22E. INJURY OCCURRED
WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Isidore Mihalakis, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

24A. BURIAL (CREMATION)
REMOVAL (Specify)

24B. DATE

1-7-70

24C. NAME OF CEMETERY or CREMATOR

24D. LOCATION (City, town, or county) (State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

JAN 7 1970

R. E. Fisher, M.D.

MORTUARY SERVICE

BCHD

1911

THE NATIONAL BUREAU OF INVESTIGATION

ACADEMY

RECORDS

NOV

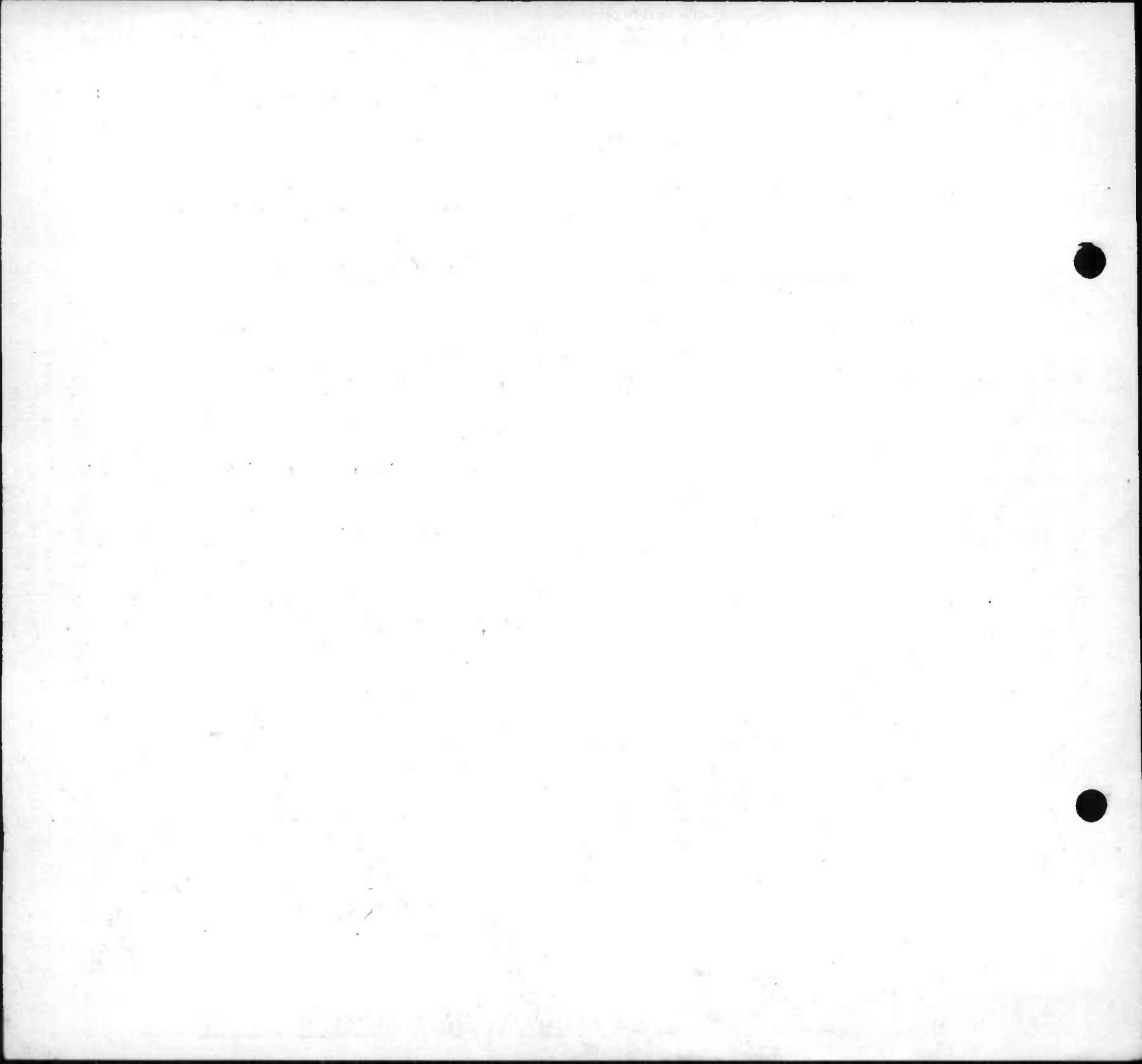


1911

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>69 13174</u>
<div style="font-size: 2em; font-weight: bold;">R-200</div> <div style="font-size: 1.5em; font-weight: bold;">69 13174</div>		<div style="font-size: 1.2em;">BIRTH NO.</div> <div style="font-size: 1.2em;">CERTIFICATE OF DEATH</div>		
1. NAME OF DECEASED (Type or Print) Beatrice RICH		2. DATE AND HOUR OF DEATH 11/23/69 11:55 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) The Johns Hopkins Hospital 33		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 807 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2041 Llewelyn Avenue		
5. SEX F	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 12/4/25	9. AGE (In years lost birthday) 44
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
18. 487X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Meningitis, pneumococcal ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Pneumococcal pneumonia		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cachexia, dehydration (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH few days few weeks
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date _____ and hour _____ and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE 23C. PHYSICIAN'S NAME (Type) Richard Harvey Glew MD				23B. DATE SIGNED 11/24/69
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 1-7-70		24C. NAME OF CEMETERY or CREMATION
25A. DATE REC'D BY HEALTH DEPT. JAN 7 1970		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR ADDRESS MORTUARY SERVICE - BCHD



C-452 69 13175 BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 69 13175

BIRTH NO. 68-00041

1. NAME OF DECEASED (Type or Print) EDWARD E. COLLINS		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 12 18 69 Hour 1:45 p.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 34 Bon Secours Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour December 18, 1969 1:45 p.m.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1901	
9. DATE OF BIRTH		10. AGE (In years last birthday) 2	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT		ADDRESS	

19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 795 X 1 ANTecedent CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(A) IMMEDIATE CAUSE Sudden death in infancy DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
--	--	--	--	--	--

20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) YES	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, public bldg., etc.)		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	

23. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE **Isidore Mihalakis, M.D.** M.D. CHIEF MEDICAL EXAMINER ☐
 EXAMINER'S NAME (Type) ASSISTANT MEDICAL EXAMINER ☒ DATE SIGNED
 ASSOCIATE MEDICAL EXAMINER ☐

24A. BURIAL CREMATION REMOVAL (Specify)		24B. DATE 1-7-70		24C. NAME OF CEMETERY ANATOMY BOARD OF MARYLAND		24D. LOCATION (City, town or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 7 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR UNIVERSITY MEDICAL SCHOOL		25D. ADDRESS MORTUARY SERVICE - BCHD	

... road Exam. said child was 2 yrs old - P.M. 1-8-69

1

S-620

69 13176

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 13176

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

GEORGE SHARROCK, JR.

2. DATE
OF DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

December 9, 1969

5:28 P.

5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

Maryland

2201

6. SEX

Male

7. RACE

White

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐ NO ☐

9. DATE OF BIRTH

10. AGE (In years
last birthday)

41

If Under 1 Yr. If Under 24 Hrs.
Months: Days: Hours: Min.

E. STREET AND NUMBER

707 Light Street

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

19.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

CAUSE OF DEATH

Arteriosclerotic Cardiovascular Disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Ronald N. Kornblum, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/10/69

24A. BURIAL (CREMATION)
REMOVAL (Specify)

24B. DATE

1-7-70

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

JAN 7 1970

Robert E. Fisher, M.D.

ANATOMY BOARD OF MARYLAND
UNIVERSITY MEDICAL CENTER
MORTUARY SERVICE - BCHD

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-300 69 13177				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 13177	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Lee Robert White				2. DATE AND HOUR OF DEATH 29 December 69 7:15 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 The Johns Hopkins Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 833 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1436 N Milton Avenue			
5. SEX M	6. RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-28-1920	9. AGE (In years last birthday) 49	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) construction work				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Georgia	
13. FATHER'S NAME Eddie White				14. MOTHER'S MAIDEN NAME Katie Taylor			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 259-01-6844		17. INFORMANT Evelyn Sherman, niece	
18. 560,917-303,2 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Aspiration pneumonia ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Probable small bowel obstruction				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hour Approx 1-2 days			
II				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Chronic alcoholism, nutritional deficiency anemias, gram-negative pneumonia.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) <u>(this hospital)</u> attended the deceased from 22 Dec 1969 to 29 Dec 1969 , that (I) <u>(we)</u> last saw the deceased alive on 29 Dec 1969 and that <u>(my)</u> <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE W. J. Rogers M.D.						23B. DATE SIGNED 29 Dec 69	
23C. PHYSICIAN'S NAME (Type) W. J. Rogers MD				23D. ADDRESS Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-3-70		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 7 1970		25B. NAME OF REGISTRAR Rebecca J. [unclear]		25C. FUNERAL DIRECTOR Randolph J. Lelick		ADDRESS 2431 E. Oliver St.	

1900 - 1901

Marie Taylor

Edna White

Student

For Mrs. J. H. Taylor, 1900-1901
Pamphlet for Mrs. J. H. Taylor

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1-240		69 13178		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 13178	
BIRTH NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>MADELINE S. Yeagle</u>				12/31/69 11:33 PM M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY	
44		Union Memorial Hosp.		Balto. City Md.		2714	
5. SEX		6. RACE		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
F		W		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		E. STREET AND NUMBER			
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		6-4-96		4401 FALLS Rd			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday)		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
HOUSEWIFE		-		73			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Edward M SPATH				LAURA ANTHON			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				B 216639425		GEORGE E YEAGLE 4401 Falls Road	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				Cardiac arrest 1 hour			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) Myocardial infarct			
				(C) A-S-CVD. -			
II				STROKE - RT Hemiplegia			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, and that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE						23B. DATE SIGNED	
[Signature] (W. MEIER-H.D.)						1-1-70	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		1-5-70		Druid Ridge Cem.		Balto Co Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JAN 8 1970		[Signature]		Byrd B. FUNERAL HOME		Falls Rd	

12. 1. 1944

Mr. J. H. ...

12. 1. 1944

Mr. J. H. ...

- 0.2.2.1

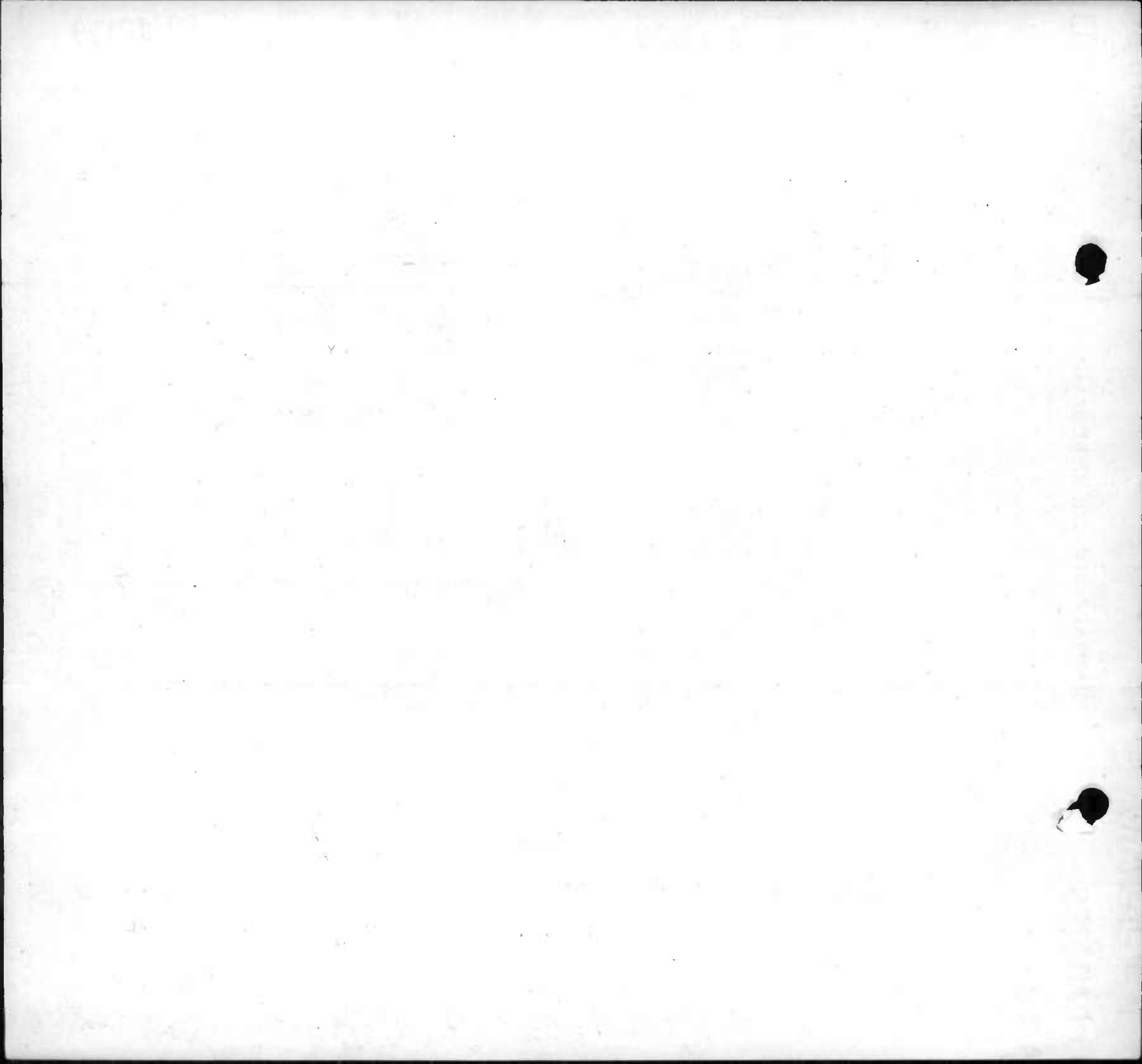
STOCKS - RT. 11. 1944

(W. H. 1. 1944) J. H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

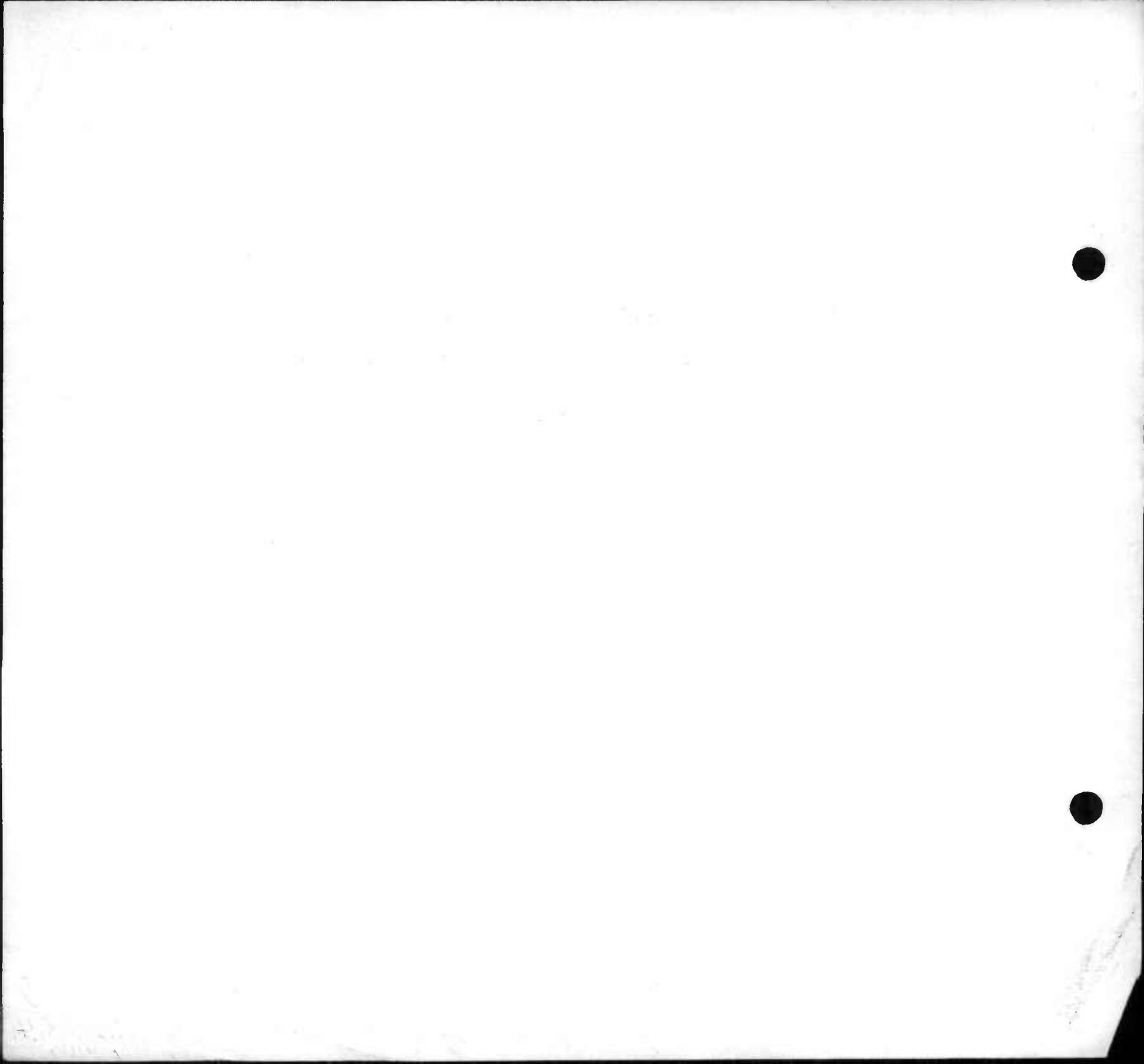
BIRTH NO. S-152		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 13179	
1. NAME OF DECEASED (Type or Print) Lee Spencer			2. DATE AND HOUR OF DEATH 12-30-69 12¹⁵ P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Johns Hopkins Hospital 33			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY CHARLES C. CITY OR TOWN WALDORF D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER BOX 155		
5. SEX MALE	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 3-19-27	9. AGE (In years last birthday) 42	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tobacco worker		10B. KIND OF BUSINESS OR INDUSTRY Tobacco		11. BIRTHPLACE (State or foreign country) North Carolina	
13. FATHER'S NAME BOOKER SPENCER			14. MOTHER'S MAIDEN NAME EVA MALLOY		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 244 34 0498		17. INFORMANT WATHE SPENCER (wife) ADDRESS N.C.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.) 160.94-320.9 ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardio-vascular (B) Menningitis DUE TO, OR AS A CONSEQUENCE OF: 3 days (C) Pansinus Carcinoma extension 5 mos		
19A. DATE OF OPERATION 8-69		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Pansinus Carcinoma		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 12-1-69 to 12-30-69 , that (we) last saw the deceased alive on 12-30-69 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (not) view the body after death.					
23A. SIGNATURE Stephen Vanderveen M.D.				23B. DATE SIGNED 12-30-69	
23C. PHYSICIAN'S NAME (Type) STEPHEN VANDERVEEN M.D.				23D. ADDRESS THE JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1-5-70		24C. NAME OF CEMETERY OR CREMATORY Lincoln Cemetery	
24D. LOCATION (City, town, or county) (State) Shoreff Rd Prop		25A. DATE REC'D BY HEALTH DEPT. JAN 8 1970			
25B. NAME OF REGISTRAR Walter H. ...		25C. FUNERAL DIRECTOR Walter H. ...			
ADDRESS WALVAN					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

N-425		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 13180	
69 13180		CERTIFICATE OF DEATH		69 13180	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		LOUIS NELSON		12-27-69 11:52 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY			
South Baltimore General Hospital		Maryland		2201	
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		802 Reardon Hall St. 21230			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days
m	Negro	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		52	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
laborer		Paperbox Factory		Virginia	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
John Nelson		Mary Robinson			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no		217-09-0328		William Nelson 834 Lemon Street	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		DUE TO, OR AS A CONSEQUENCE OF:		Aspiration Pneumonia	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:		Hypoglycemic shock	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO, OR AS A CONSEQUENCE OF:		Hepatic insufficiency (?)	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 10:30 12-26-19 69 to 11:52 P.M. 12-27-19 69 that (I) (we) last saw the deceased alive on 11:52 P.M. 12-27-19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Virginia G. Fausto, M.D.		12-27-69			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
VIRGINIA G. FAUSTO, M.D.		South Baltimore General Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		1/7/70		Mt. Auburn	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
Balto., Md.		JAN 8 1970		Robert E. Taylor, Jr.	
25C. FUNERAL DIRECTOR		25D. ADDRESS			
B. Brown, Son		123 W. Montgomery St.		Baltimore, Md.	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED
(Type or Print)

STOCKETT DUVALL

2. DATE
OF DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

M.

December 25, 1969

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

00 125 W. Cross Street

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

December 25, 1969

12:50 A.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

2301

6. SEX

Male

7. RACE

Negro

B. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

10. AGE (In years
last birthday)

77

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

125 W. Cross Street

11. BIRTHPLACE (State or foreign country)

Va

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

Hilda Bond

125 W. Cross Street

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

Arteriosclerotic cardiovascular disease

(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(b)

DUE TO, OR AS A CONSEQUENCE OF:

(c)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

December 25, 1969

24A. BURIAL CREMATION,
REMOVAL (Specify)

burial

24B. DATE

12/29/69

24C. NAME of CEMETERY or CREMATORY

Mt. Calvary

24D. LOCATION (City, town, or county) (State)

Anne Arundel County

25A. DATE RECEIVED BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

25D. ADDRESS

ACADEMY BOARD

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John D. White

1. NAME OF DECEASED (Type or Print) Charles Kosh		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 40 St. Agnes Hospital (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year Hour 12 21 69 4:35 P.M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY Howard C. CITY OR TOWN Simpsonville D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 6300	
9. DATE OF BIRTH		10. AGE (In years lost birthday) 55	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT		ADDRESS	

19. E816.10 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH Fracture of the cervical spine (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					

20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? State Rte. 32 300' east of U.S. 29	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 12-21-69 3:50P.m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Subj. driver in car that ran off road, struck tree and overturned.	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Russell S. Fisher, M.D. M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12-22-69					

24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/27/69		24C. NAME OF CEMETERY or CREMATORY Hopkins Cemetery Highland, Md.		24D. LOCATION (City, town, or county) (State) Rockville Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 8 1970		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR Robert L. Suonden		ADDRESS Rockville Md.	

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 13183

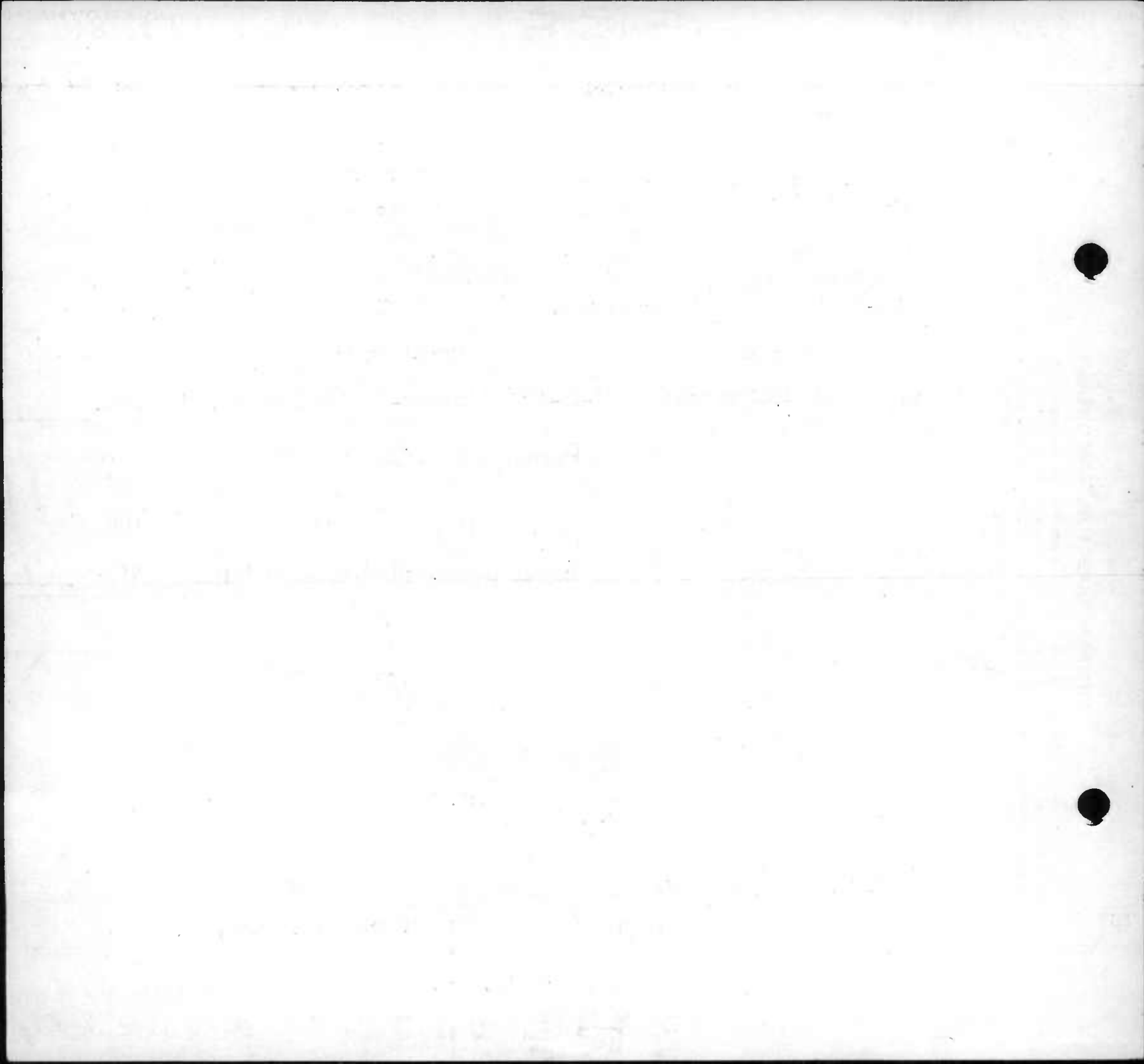
BIRTH NO.

1. NAME OF DECEASED (Type or Print) JAMES CROCKER				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> December 31, 1969		Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 24 E. Mt. Vernon Place				3. DATE PRONOUNCED DEAD Month Day Year December 31, 1969		Hour 7:40 P.M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1102							
6. SEX Male	7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH MAY 12, 1912		10. AGE (In years last birthday) 57		11. BIRTHPLACE (State or foreign country) CALIFORNIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME UNKNOWN		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		15. MOTHER'S MAIDEN NAME UNKNOWN		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO.		18. INFORMANT JAMES HERBERSON, 62 E. HEATH ST.		ADDRESS BALTO., MD.			
19. 412.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Hypertensive and arteriosclerotic (A) IMMEDIATE CAUSE cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) Yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED January 1, 1970							
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7 JAN 70		24C. NAME OF CEMETERY or CREMATORY Cedar Hill Cem.		24D. LOCATION (City, town, or county) (State) BALTO. MD	
25A. DATE REC'D BY HEALTH DEPT. JAN 8 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ST. NICHOLAS FUNERAL HOME, 1300 N. E. MD			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
69 13184					CERTIFICATE OF DEATH					
BIRTH NO.					REG. NO. 69 13184					
1. NAME OF DECEASED (Type or Print) NORMAN FREDERICK MUENCH					2. DATE AND HOUR OF DEATH Dec. 31, 1969 11: 20 A.M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Va. B. COUNTY V-43					
FULL NAME OF HOSPITAL OR INSTITUTION US Public Health Service Hospital 3100 Wyman Parkway					C. CITY OR TOWN Woodbridge					
(If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)					D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>					
E. STREET AND NUMBER 12 Pine Avenue										
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/8/18	9. AGE (In years last birthday) 51	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CWO-4				10B. KIND OF BUSINESS OR INDUSTRY US Coast Guard		11. BIRTHPLACE (State or foreign country) NY		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Frank Muench					14. MOTHER'S MAIDEN NAME Teresa Zeyer					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service) Yes CG 1940 to date				16. SOCIAL SECURITY NO. 077-07-2053		17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md.				
18. 22771 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Pulmonary Emboli, massive (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Left hip prosthesis (B) DUE TO, OR AS A CONSEQUENCE OF: Hemangioendothelioma of hip (C)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH min. mo. yrs.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).										
19A. DATE OF OPERATION 2			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from Oct. 29 19 69 to Dec. 31 19 69 , that (I) (we) last saw the deceased alive on Dec. 31 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (d/d/p/f) view the body after death.										
23A. SIGNATURE Samuel P. Ward, M.D.						Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED		
23C. PHYSICIAN'S NAME (Type) Samuel P. Ward, M.D.						23D. ADDRESS US PHS Hospital, Balto, Md.				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 1/2/70			24C. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cem.		24D. LOCATION (City, town, or county) (State) Arlington, Virginia		
25A. DATE REC'D BY HEALTH DEPT. JAN 9 1970			25B. NAME OF REGISTRAR Robert E. Taylor, Jr.			25C. FUNERAL DIRECTOR Falls Church F.H. 1102 W. Broad Falls Church, Va.			ADDRESS	



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W 426

69 13185

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 13185

BIRTH NO.		REG. NO.	
1. NAME OF DECEASED (Type or Print) HERBERT H. WALKER		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year December 3, 1969 Hour 9:03 A.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH Jan 15 1929		10. AGE (In years last birthday) 40	
11. BIRTHPLACE (State or foreign country) N.C.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Robert Walker		14. MOTHER'S MAIDEN NAME Harriette	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labourer		16. KIND OF BUSINESS OR INDUSTRY	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		18. SOCIAL SECURITY NO.	
19. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Epilepsy II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12/3/69			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Dec 9 1969	
24C. NAME OF CEMETERY OR CREMATORY Bell Natl Cem		24D. LOCATION (City, town, or county) (State) 5501 Fennell Rd	
25A. DATE REC'D BY HEALTH DEPT. JAN 9 1970		25B. NAME OF REGISTRAR Miller & Plummer	
25C. FUNERAL DIRECTOR 1129 N. Carroll		ADDRESS	

10-10-68

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

TO : DIRECTOR, FBI (100-441100)
FROM : SAC, NEW YORK (100-100000) (P)
SUBJECT: [Illegible]

RE: [Illegible]

DATE: [Illegible]

BY: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 13186	
BIRTH NO. 69-24246		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Baby Boy THOMPSON		2. DATE AND HOUR OF DEATH 12-31-69 11:30 PM.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD LUTHERAN Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 15-11	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) LUTHERAN Hospital		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 332 E 22nd ST			
5. SEX M	6. RACE negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12.31.69
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 1 hr old
11. BIRTHPLACE (State or foreign country) LUTHERAN Hospital		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Earl W. CARTER		14. MOTHER'S MAIDEN NAME THOMPSON BERINE	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
18. 777X I		CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: immaturity	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 to 19 , that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE M S Kook		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) MIN JA KOOK		23D. ADDRESS ANATOMY BOARD OF MARYLAND	
24A. BURIAL CREMATION, REMOVAL (Specify) 1-8-70		24B. NAME OF CEMETERY UNIVERSITY MEDICAL SCHOOL	
25A. DATE REC'D BY HEALTH DEPT. JAN 13 1970		25B. NAME OF REGISTRAR Bob E. Taylor, 629 0	
25C. FUNERAL DIRECTOR ADDRESS MORTUARY SERVICE - BCHO			

address should be
4024 Grantly Rd. Called hospital

Birth certificate shows: Baby boy Carter

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-236 BALTIMORE CITY HEALTH DEPARTMENT	
BIRTH NO. <u>69-24528</u> 69 13187	CERTIFICATE OF DEATH
REG. NO. <u>69 13187</u>	
1. NAME OF DECEASED (Type or Print) <u>Foster Baby</u>	
2. DATE AND HOUR OF DEATH <u>Dec. 31 '69</u> <u>5:10p M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>Sinai Hosp. of Baltimore</u>	
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>2788</u>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Sinai Hosp. of Baltimore</u>	
C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>5309 Beaufort Ave</u>	
5. SEX <u>F</u>	6. RACE <u>N</u>
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 31 '69</u>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) <u>21</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <u>William H. Foster</u>	
14. MOTHER'S MAIDEN NAME <u>Valarie</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
17. INFORMANT ADDRESS	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Prematurity</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <u>2</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>Dec 31</u> <u>19 69</u> to <u>5:10pm Dec 31 19 69</u> that (I) (we) last saw the deceased alive on <u>5:10pm Dec 31 19 69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE <u>Thomas P. Oh</u>	23B. DATE SIGNED <u>Dec. 31 '69</u>
23C. PHYSICIAN'S NAME (Type) <u>HYUN T. OH</u>	23D. ADDRESS <u>ANATOMY BOARD OF MARYLAND</u>
24A. BURIAL CREMATION REMOVAL (Specify) <u>1-7-70</u>	24B. DATE
24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 13 1970</u>	25B. NAME OF REGISTRAR <u>UNIVERSITY MEDICAL SCHOOL</u>
25C. MORTUARY SERVICE	25D. ADDRESS

418, 84 - 418 - 2 - 1 1878 - 20

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>69-22033</u>		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. <u>69 13188</u>
1. NAME OF DECEASED (Type or Print) <u>Baby Boy Stafford</u>		2. DATE AND HOUR OF DEATH <u>11/28/69</u> <u>11:55 A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>12 Sinai Hospital of Baltimore</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>12 Sinai Hospital of Baltimore</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <u>309 E. 22nd St #18</u>				
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/27/69</u>	9. AGE (In years last birthday) <u>23</u> <u>39</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>YUONN</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>ADDRESS</u>
18. <u>776.11</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Hyaline Membrane Dis</u> (B) <u>Tension Pneumothorax</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs.</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>11/27/69</u> 19 to <u>11/28/69</u> 19 that (I) (we) last saw the deceased alive on <u>11/28/69</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Todd Gladstone, MD.</u>		23B. DATE SIGNED <u>11/28/69</u>		23C. PHYSICIAN'S NAME (Type) <u>Todd Gladstone, MD.</u>
23D. ADDRESS <u>Anatomy Board of Maryland</u>		23E. CITY, TOWN, OR COUNTY <u>Baltimore</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>1-13-70</u>		24B. DATE <u>1-13-70</u>		24C. NAME OF CEMETERY <u>UNIVERSITY MEDICAL SCHOOL</u>
24D. LOCATION <u>Baltimore</u>		24E. STATE <u>Maryland</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 13 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>MORTUARY SERVICE - BCHO</u>

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-52069-21920 69 13189		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 69 13189	
BIRTH NO. [REDACTED]		1. NAME OF DECEASED (Type or Print) BABY BOY JONES		2. DATE AND HOUR OF DEATH 11/25/69 6:40 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SINAI HOSPITAL OF BALTIMORE 42		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE CITY C. CITY OR TOWN BALTIMORE CITY D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4806 Harstestown Rd.			
5. SEX M	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-24-69	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND, MD	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME VIRLEEN JONES		14. MOTHER'S MAIDEN NAME OLIVIA JONES			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. NONE		17. INFORMANT ADDRESS	
18. 776821 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenic, etc. It means the disease, injury or complication which caused death.) CARDIAC ARREST		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: SEVERE RESPIRATORY ACIDOSIS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: (c) Respiratory distress syndrome		24 hrs.	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) 0 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nearly medical examined) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Nov 24 1969 to Nov 25 1969 that (I) (we) last saw the deceased alive on Nov 25 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ruth Ashman, M.D.		23B. DATE SIGNED 11/25/69		23C. PHYSICIAN'S NAME (Type) Ruth Ashman	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 1-7-70		24C. NAME OF CEMETERY SINAI HOSPITAL	
25A. DATE REC'D BY HEALTH DEPT. JAN 13 1970		25B. NAME OF REGISTRAR Robert E. Talley, M.D.		25C. ADDRESS UNIVERSITY MEDICAL SCHOOL	
MORTUARY SERVICE - BCHD					

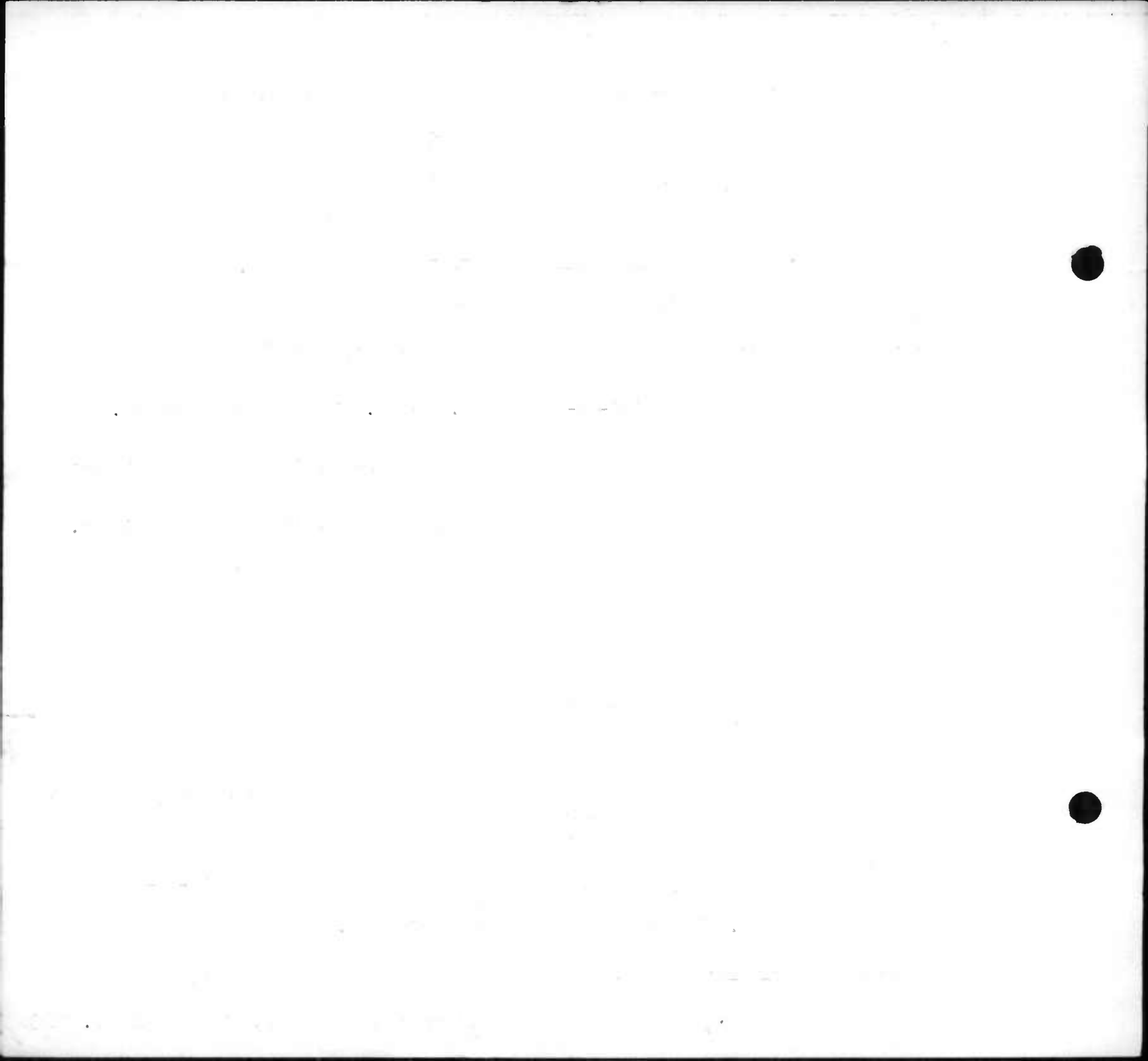
~~SECRET~~

note map

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-625		69 13190		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 13190	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Carolena Burgemeister				2. DATE AND HOUR OF DEATH December 22, 1969			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 Long Green Nursing Home				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2636			
				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 4508 Parkmont Avenue			
5. SEX Female	6. RACE Cau.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-28-1887	9. AGE (In years last birthday) 82 yrs.	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Langenfelder				14. MOTHER'S MAIDEN NAME Margaret Graf (Graf)			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 213-60-4284	17. INFORMANT ADDRESS Mrs. Ruth A. Ries 4508 Parkmont Ave. 21206			
18. CAUSE OF DEATH							
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Bronchopneumonia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days	
				(B) DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerosis		3 yrs.	
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from September 19 69 to December 22 19 69 that (I) (we) last saw the deceased alive on December 20 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Conrad L. Richter</i>				23B. DATE SIGNED 12-23-69		23C. PHYSICIAN'S NAME (Type) Conrad L. Richter	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-24-69		24C. NAME OF CEMETERY or CREMATORY Western Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 13 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Lassahn Funeral Home		ADDRESS 7401 Belair Rd. 21236	



B-435

69 13191

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 13191

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

CHARLES SYLVESTUS BALDWIN

2. DATE
OF
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Mercy Hospital (DOA)

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

12

14

69

9:15 P

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

2544

6. SEX

Male

7. RACE

White

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

Aug. 2, 1931

10. AGE (In years
lost birthday)

38

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

823 Stoll St.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

George R. Baldwin

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

Construction

15. MOTHER'S MAIDEN NAME

Laurs Ebaugh

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

Korean War

17. SOCIAL
SECURITY NO.

216 28 1967

18. INFORMANT

Mrs. Joan E. Baldwin

ADDRESS

Same

19.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

CAUSE OF DEATH

Conflagration

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS

UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., In or about
home, farm, factory, street, office bldg., etc.)

factory

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Lombard and Commerce Sts. 401

22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)

12

14

69

8:10P

22E. INJURY OCCURRED
WHILE AT ☐ NOT WHILE AT ☒
WORK WORK

22F. HOW DID INJURY OCCUR?

Subject trapped in fire

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Russell S. Fisher M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1-8-70

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

1/13/70

24C. NAME of CEMETERY or CREMATORY

Baltimore National

24D. LOCATION (City, town, or county)

(State)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

JAN 13 1970

25B. NAME OF REGISTRAR

Robert S. Fisher, M.D.

25C. FUNERAL DIRECTOR

George J. Gonce 4001 Ritchie Hwy.
Baltimore, Maryland 21225

ADDRESS

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ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 10-10-83 BY SP-6 JAC/STP

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NON MED PER DR. KORNBLOOM
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

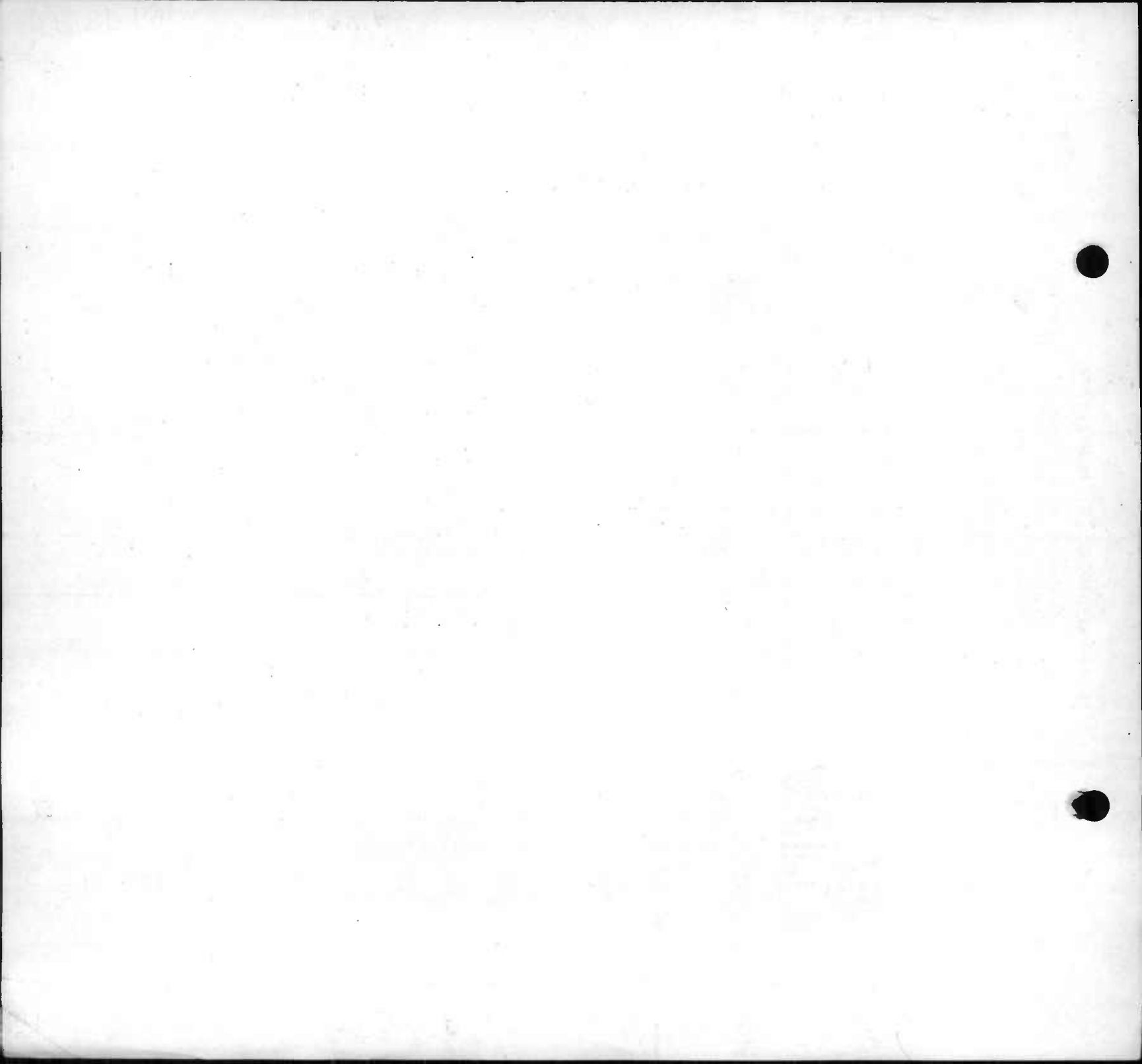
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 13192	
69 13192				CERTIFICATE OF DEATH	
BIRTH NO.				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) GEORGE FRANKLIN				Dec 2, 1969 5:00 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
33 THE JOHNS HOPKINS HOSPITAL				MARYLAND	
				C. CITY OR TOWN D. INSIDE CITY LIMITS?	
				BALTIMORE YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER	
				2304 E. NORTH AVENUE	
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
MALE	NEGRO	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8-14-14	55	10A. LABORER
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
James Franklin			Katherine Jackson		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, No or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT			ADDRESS		
Margaret Franklin			2304 E. North Ave		
18. CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			TERMIAL Ca of pancreas 8 mos		
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES			D.O.A.		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			(C) DUE TO, OR AS A CONSEQUENCE OF:		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from Dec 2, 1969 to 19, that (I) (we) lost saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Nicholas A. Volpicelli M.D.				12/2/69	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
NICHOLAS A. VOLPICELLI				THE JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		12/6/69		Burr Hill Cem	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JAN 13 1970		Robert E. Jackson, M.D.		Milton E. Elikan 1129 N. Carroll St	

1871

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 13193	
BIRTH NO. 68-16909 69 13193		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Cynthia Brown		2. DATE AND HOUR OF DEATH December 22, 1969 at 5:45 PM M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNIVERSITY OF MARYLAND HOSPITAL 38		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX F		6. RACE N		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 9/4/68		9. AGE (In years last birthday) 1 yr.		10. CITIZEN OF WHAT COUNTRY? U. S. A	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baby		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Baltimore, Md	
13. FATHER'S NAME Josephs Brown		14. MOTHER'S MAIDEN NAME Jeannette Clash.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. —		17. INFORMANT Jeannette Clash 3501 Gelston Dr.	
18. 34791 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ASPIRATION		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hours			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) To be determined (C) —			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Hydrocephalus & shunts					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Dec 22 19 69 to Dec 22 19 69 and that (I) (we) last saw the deceased alive on Dec 22 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Carol M. Rumsch MD		23B. DATE SIGNED 12/22/69		23C. PHYSICIAN'S NAME (Type) UNIV OF MD.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/27/69		24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 13 1970		25B. NAME OF REGISTRAR R. E. J. 900		25C. FUNERAL DIRECTOR 1900 E. F. W. M. BALT. MD.	



S-530

69 13194

BALTIMORE CITY HEALTH DEPARTMENT

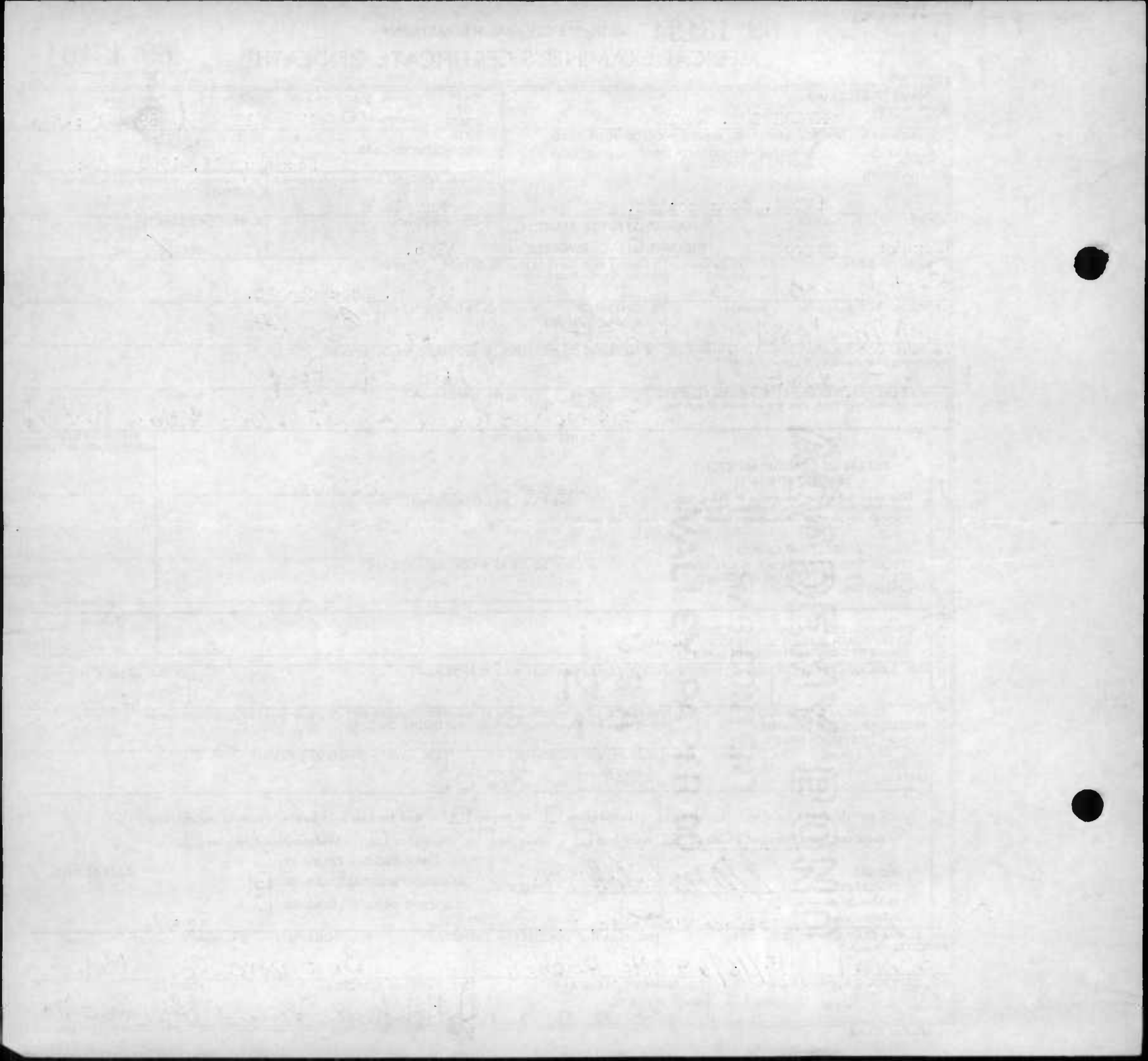
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 13194

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MILDRED B. SMITH		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 12 11 69 10:15 p.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 00 112 S. Stockton St. (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year Hour December 11, 1969 10:15 p.	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1803		6. SEX Female 7. RACE Negro 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH Sept. 4, 1930		10. AGE (In years last birthday) 39	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Everett		14. MOTHER'S MAIDEN NAME Mildred Beck	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		16. KIND OF BUSINESS OR INDUSTRY	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		18. SOCIAL SECURITY NO. 218-26-5155	
19. 375.7		20. CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE Epilepsy DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Isidore Mihalakis, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12/16/69	
24C. NAME OF CEMETERY or CREMATORY MT. AUBURN		24D. LOCATION (City, town, or county) (State) Baltimore, Co. Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 13 1970		25B. NAME OF REGISTRAR Robert E. Haber, M.D.	
25C. FUNERAL DIRECTOR B. J. Baker		ADDRESS Baltimore, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-325		69 13195		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 13195	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) WATKINS MARY			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				2. DATE AND HOUR OF DEATH Dec. 29, 1969 2-15 A.M.			
FULL NAME OF HOSPITAL OR INSTITUTION Lushneran Hospital of MD 46		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD B. COUNTY 1304		C. CITY OR TOWN Baltimore	
5. SEX F		6. RACE (C) Bapt		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-2-06 62 yr	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DOMESTIC		10B. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Jones				14. MOTHER'S MAIDEN NAME Mattie Watkins			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-36-3556		17. INFORMANT ADDRESS			
18. 135.01		CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hepatosoma					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Portal cirrhosis DUE TO, OR AS A CONSEQUENCE OF:					
(C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 0 -		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED -		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) -		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) -		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) -		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? -			
22. I certify that (I) (this hospital) attended the deceased from 10-27-1969 to 12-29-1969 that (I) (we) last saw the deceased alive on 12-29-1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Kantilal J Shah MD				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12/29/69	
23C. PHYSICIAN'S NAME (Type) KANTILAL J SHAH MD				23D. ADDRESS Lushneran Hospital of MD			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1/6/70		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn		24D. LOCATION (City, town, or county) (State) Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT. JAN 13 1970		25B. NAME OF REGISTRAR Robert E. [illegible]		25C. FUNERAL DIRECTOR ADDRESS Bob [illegible] Baltimore, Md.			

Posterior cisterna
Hepatic

10-51-75-01
15-51-75-01

12/1/1914

7-10-1968

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
69 13196					69 13196				
BIRTH NO.					CERTIFICATE OF DEATH				
1. NAME OF DECEASED (Type or Print) <i>William U. Davis</i>					2. DATE AND HOUR OF DEATH <i>Dec 28 - 1969</i> <i>1:55 A.</i> M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>806</i>				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>MT Sinai Nursing Home</i> <i>704613 Park Heights Ave.</i>					C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX <i>Male</i> 6. RACE <i>Negro</i> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <i>3/10/85</i>		9. AGE (In years last birthday) <i>84</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>
11. BIRTH PLACE (State or foreign country) <i>Checker Saw, Miss</i>					12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>				
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME <i>Matte Davis</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>					16. SOCIAL SECURITY NO. <i>337-24 2119</i>		17. INFORMANT <i>Nursing Home Records</i>		
18. <i>185X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH <i>Carcinoma of Prostate</i> <i>Metastases</i>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>?</i>				
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <i>Aug 21</i> 19 <i>69</i> to <i>Dec 27</i> 19 <i>69</i> and that in (my) <i>own</i> opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Louis T. Lavy</i>					23B. DATE SIGNED <i>Jan 2 - 1970</i>			23C. PHYSICIAN'S NAME (Type) <i>LOUIS T. LAVY</i>	
23D. ADDRESS <i>3502 W. Lamar Ave Baltimore Md.</i>					23E. DATE REC'D BY HEALTH DEPT. <i>JAN 9 1970</i>				
23F. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>					23G. FUNERAL DIRECTOR <i>Joseph P. Rives 2222 W. North Ave.</i>				
23H. ADDRESS <i>2222 W. North Ave.</i>					23I. ADDRESS				

White House
Washington, D.C.

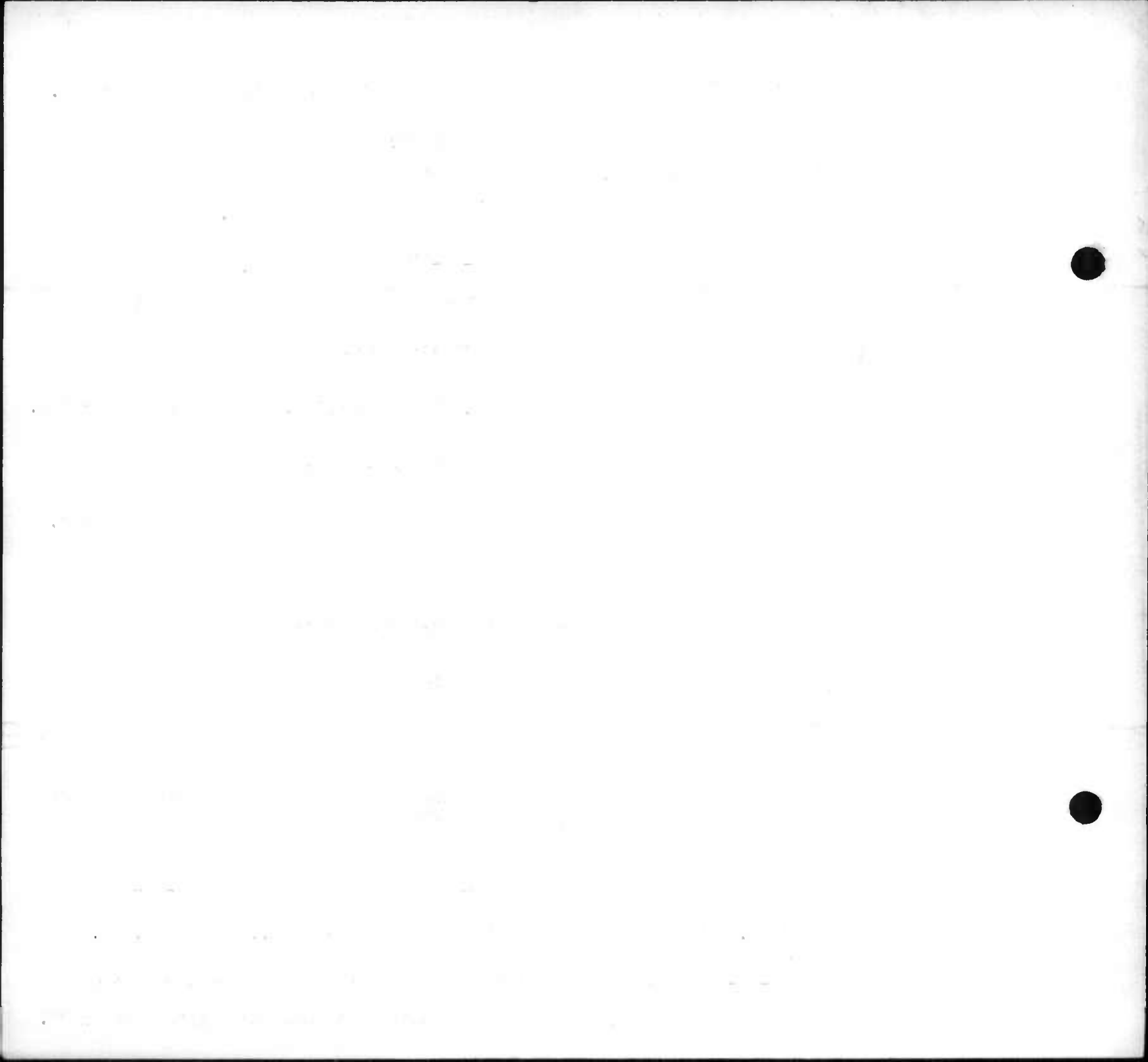
May 1965

100-444444-100
George A. Jones, Jr.
President, American Society of
International Law

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

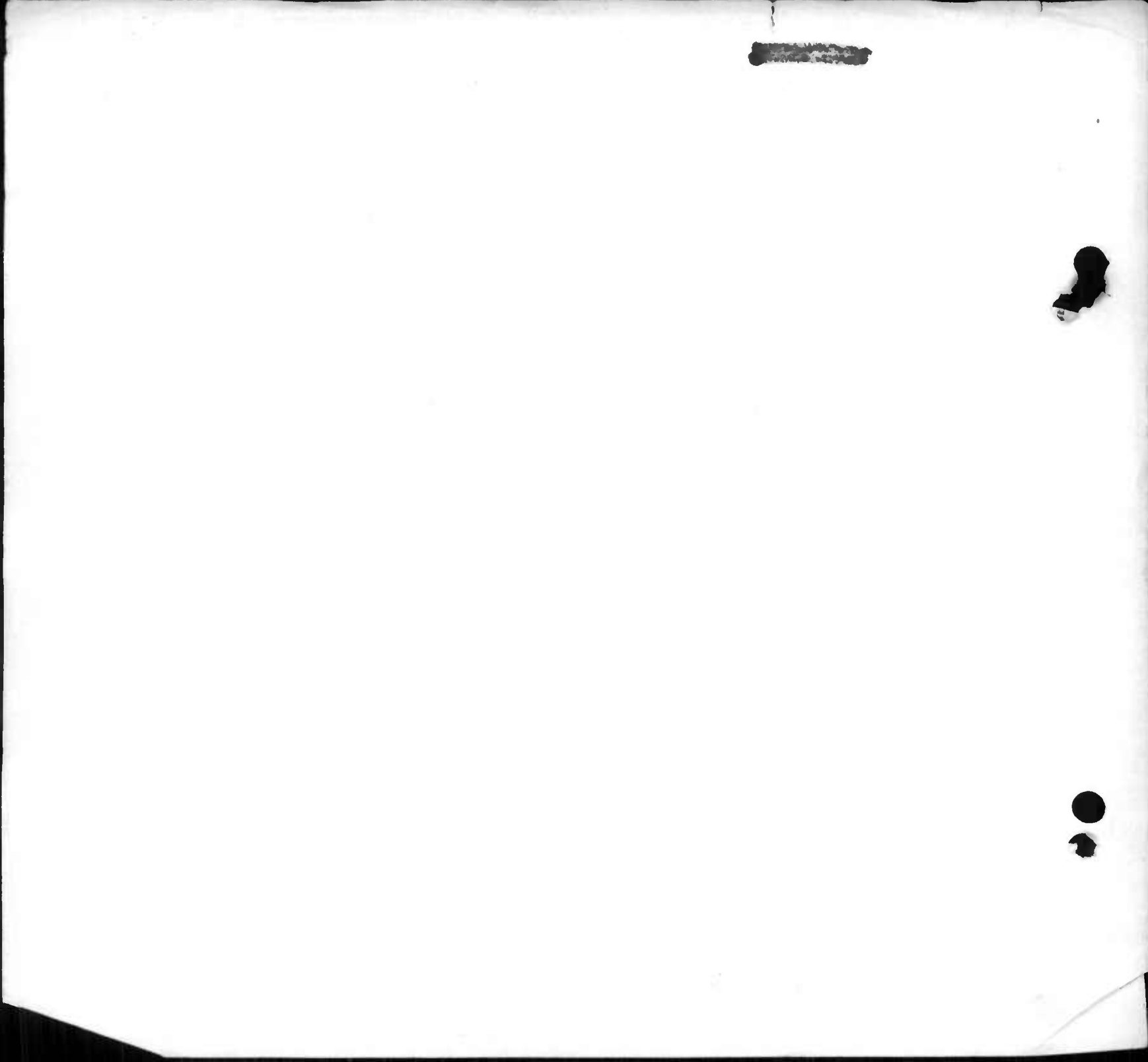
C-146 BIRTH NO. 69 13197		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 69 13197	
1. NAME OF DECEASED (Type or Print) Rona Cavalier			2. DATE AND HOUR OF DEATH December 21, 1969 7:00 A. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 6058 Green Meadows Pkwy.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2755 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 6058 Green Meadows Pkwy.		
5. SEX Female	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-10-30	9. AGE (In years last birthday) 39 yrs.	If Under 1 Yr. Months: Days: If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Morris Scherr		
14. MOTHER'S MAIDEN NAME Tillie Milston			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO.			17. INFORMANT Mr. Harold Cavalier, 6058 Green Meadows Pkwy. ADDRESS		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pulmonary Edema ANTECEDENT CAUSES ASCVD DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 3 yrs.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Uncontrolled diabetes mellitus					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 19 69 to December 19 69 that (I) (we) last saw the deceased alive on Dec. 20 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Arthur A. Serpeck</i>				23B. DATE SIGNED 12-21-69	
23C. PHYSICIAN'S NAME (Type) Arthur A. Serpeck				23D. ADDRESS 6000 Park Heights Ave., Baltimore, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-22-69		24C. NAME OF CEMETERY OR CREMATORY Hebrew Young Mens	
24D. LOCATION (City, town, or county) (State) Windsor Mill Road, Maryland		25A. DATE REC'D BY HEALTH DEPT. JAN 14 1970			
25B. NAME OF REGISTRAR Sol Levinson		25C. FUNERAL DIRECTOR ADDRESS Sol Levinson & Bros. 6010 Reisterstown Rd.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				69 13198	
H-63069-2392969 13198				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Baby Boy Howard		12/22/69 11AM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
UNIV. OF MARYLAND UNIV. HOSP. 38			MARYLAND BALTIMORE 907		
			C. CITY OR TOWN D. INSIDE CITY LIMITS?		
			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER					
2722 The Alameda					
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days
M	N		12/22/69		4 40
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				Baltimore, Maryland	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Willie Howard			LULA Whitaker		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO NO		None		Charl	
18. CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Respiratory distress 4 hrs 40 min		
			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			(C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 12/22 1969 to 12/22 1969 that (I) (we) lost saw the deceased alive on 12/22 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Norma J. Hazelbaker, M.D.				12/22/69	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATOR	
		1-15-70		JOHNS HOPKINS MEDICAL SCHOOL	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR'S ADDRESS	
JAN 16 1970		230 E. Eads St. Md. 9		MORTUARY SERVICE - BCHD	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 13199	
69 13199				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Hollister Theodore</u>		2. DATE AND HOUR OF DEATH <u>12/17/69 8 P.M.</u> <u>PM</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence, before admission) A. STATE <u>Harbor View Nursing Home</u> B. COUNTY <u>Harbor View</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Harbor View N.C.C.</u> <u>90 1213 Light St</u>			C. CITY OR TOWN		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-18-80</u>		9. AGE (In years last birthday) <u>89</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>W. Carolina</u>	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME <u>U.S.A.</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>154-05-2054</u>		17. INFORMANT <u>Harbor View</u>	
18. <u>412.4 92 250.9</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Diabetes mellitus</u>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>broncho pneumonia</u> <u>ant. sel. C.V. disease</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>cerebral artery scl.</u> (C) <u>2d.</u>		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (<u>this hospital</u>) attended the deceased from <u>11/28</u> 19 <u>69</u> to <u>12/17</u> 19 <u>69</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>12/17</u> 19 <u>69</u> and that in (my) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (<u>we</u>) (did not) view the body after death.					
23A. SIGNATURE <u>Kenneth Kruevitz MD</u>				23B. DATE SIGNED <u>12/18/69</u>	
23C. PHYSICIAN'S NAME (Type) <u>Kenneth Kruevitz MD</u>				23D. ADDRESS <u>115 W. Monument St Baltimore</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/16/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>W. Calvary Cems</u>	
24D. LOCATION (City, town, or county) (State) <u>Harbor View</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 16 1970</u>			
25B. NAME OF REGISTRAR <u>Robert E. Talbot, M.D.</u>		25C. FUNERAL DIRECTOR <u>1712 W. North Ave</u>			

Called Harbor View Nursing Home. address of
deceased is 1209 Audrey ave. Philadelphia, Pa.

1
S-000 69 13200 BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 69 13200

1. NAME OF DECEASED (Type or Print) DANA SHAW		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> May 22, 1969 10:10 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 38 UNIVERSITY HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year May 22, 1969 10:10 P.M.	
6. SEX Female		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
10. AGE (In years lost birthday)		E. STREET AND NUMBER 1700 Harlem Avenue 16-03	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? Leonard Jones	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME Verlyne Lewis	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT		ADDRESS	
19. 795 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH Sudden death in infancy (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 5/23/69			
24A. BURIAL CREMATION, REMOVAL (Specify) Cremated		24B. DATE 9-2-69	
24C. NAME OF CEMETERY or CREMATORY Medical Examiners Office		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 20 1970		25B. NAME OF REGISTRAR 2209 3rd St. N.E. 0 0 1 0 1 8 6	
25C. FUNERAL DIRECTOR HOSPITAL DISPOSAL		ADDRESS	

SC

1928

WALLEY

WALP

1928

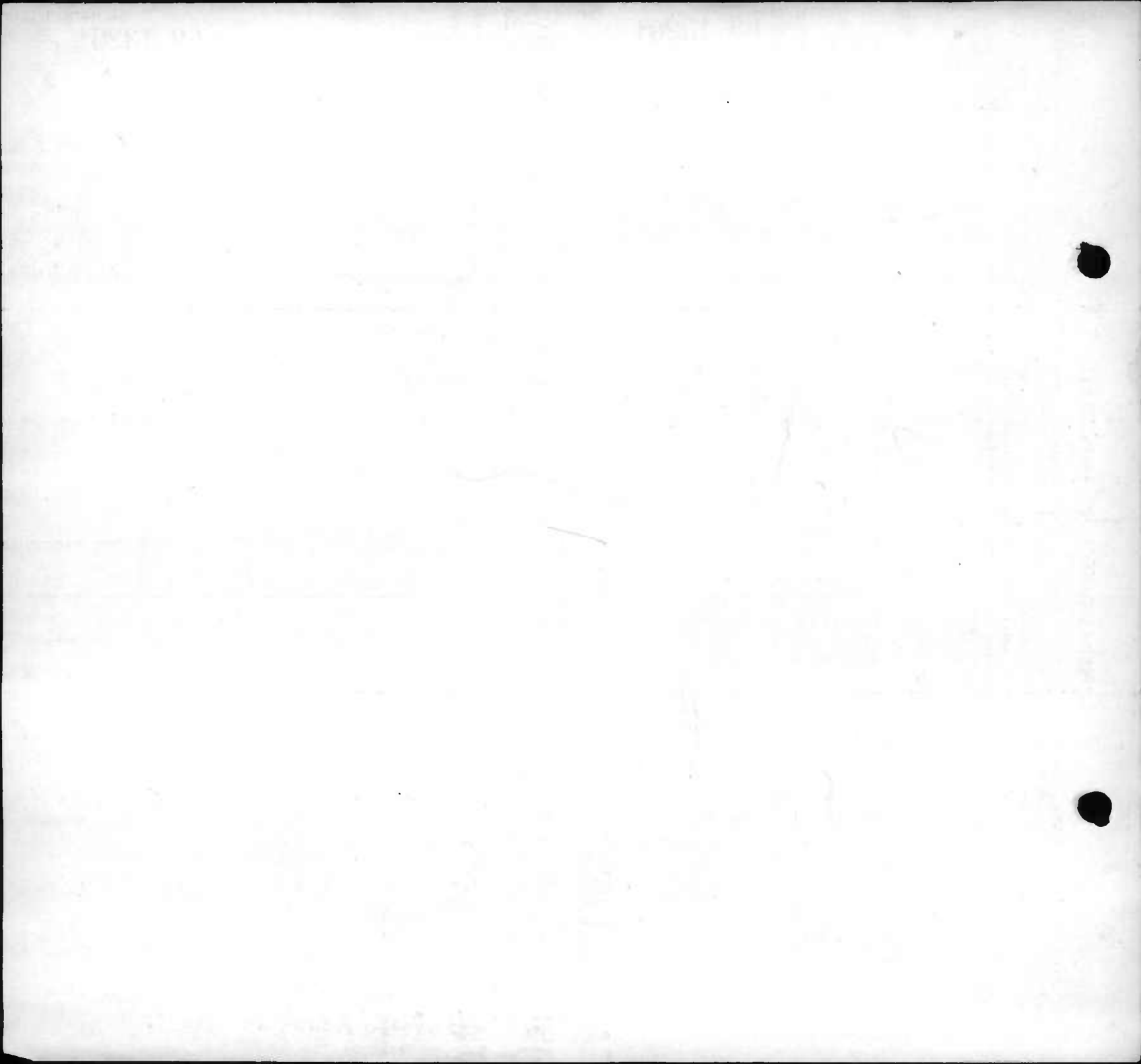
Counted 9-2-28 Medical Examiner Office Baltimore

Mr.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 69-24458		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 13201	
1. NAME OF DECEASED (Type or Print) MONIQUE RENEE COOPER		2. DATE AND HOUR OF DEATH 12/6/69 1:45 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BON SECOURS HOSPITAL 3420 35 W. Fayette St. Balt. Md. 21203		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Female		6. RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Dec. 6, 1969		9. AGE (In years last birthday) 3 months		10. Under 1 Yr. Months: Days: Hours: Min. 0 2 33	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME William Samuel Adams		14. MOTHER'S MAIDEN NAME Christine Cooper	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. 771.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Asphyxia (B) Aspiration a neck cord loop (17) (C) Duct delivery 3 hrs		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Dec. 6 19 69 to Dec. 6 19 69, that (I) (we) last saw the deceased alive on Dec. 6 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ludicina M. Oteyza MD 23C. PHYSICIAN'S NAME (Type) LUDICINA M. OTEYZA MD				23B. DATE SIGNED 12/6/69 23D. ADDRESS Don Secours Hospital Balt. Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 12/8/69		24C. NAME OF CEMETERY or CREMATORY ST. PETERS	
24D. LOCATION BALTO, Md.		25A. DATE REC'D BY HEALTH DEPT. JAN 26 1970		25B. NAME OF REGISTRAR Rosa E. J. [unclear] MD	
25C. FUNERAL DIRECTOR B/MASON KENNY INC		ADDRESS BALTO, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p>BALTIMORE CITY HEALTH DEPARTMENT</p> <p>CERTIFICATE OF DEATH</p>		<p>REG. NO. <u>69 13202 4</u></p>	
<p>G-415 69 13202</p> <p>BIRTH NO. <u>69-22623</u></p>		<p>1. NAME OF DECEASED (Type or Print) <u>BABY BOY OF ANTONETTE GLAVIANO</u></p>	
<p>2. DATE AND HOUR OF DEATH <u>12/5/69</u> <u>1:12 P.M.</u></p>		<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p>	
<p>FULL NAME OF HOSPITAL OR INSTITUTION <u>SINAI HOSPITAL OF BALTIMORE</u> <u>42</u></p>		<p>4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2005</u></p>	
<p>5. SEX <u>M</u> 6. RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <u>12/5/69</u> 9. AGE (In years last birthday) <u>Newborn</u></p>	
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CHILD</u></p>		<p>11. BIRTHPLACE (State or foreign country) <u>Sinai Hospital of Baltimore</u></p>	
<p>10B. KIND OF BUSINESS OR INDUSTRY <u>None</u></p>		<p>12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u></p>	
<p>13. FATHER'S NAME <u>Anthony Glaviano</u> <u>Unknown</u></p>		<p>14. MOTHER'S MAIDEN NAME <u>Antonette Glaviano</u></p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u></p>		<p>16. SOCIAL SECURITY NO.</p>	
<p>17. INFORMANT</p>		<p>ADDRESS</p>	
<p>18. <u>776.9</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p>CAUSE OF DEATH</p> <p><u>Apnea</u></p> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</p> <p><u>PREMATURITY</u></p> <p>(B) DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) _____</p>	
<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>40 min.</u></p>		<p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>	
<p>19A. DATE OF OPERATION <u>0</u></p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	
<p>20A. AUTOPSY? (Yes or No)</p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)</p>	
<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from <u>12/5/69</u> 19 to <u>12/5/69</u> 19, that (I) (we) lost saw the deceased alive on <u>12/5/69</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE <u>Ruth Ashman, M.D.</u></p>		<p>23B. DATE SIGNED <u>12/5/69</u></p>	
<p>23C. PHYSICIAN'S NAME (Type) <u>Ruth Ashman, M.D.</u></p>		<p>23D. ADDRESS <u>Sinai Hospital</u></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <u>1-16-70</u></p>		<p>24B. DATE</p>	
<p>24C. NAME OF CEMETERY <u>JOHNS HOPKINS MEDICAL SCHOOL</u></p>		<p>24D. LOCATION (City, town or county) (State)</p>	
<p>25A. DATE REC'D BY HEALTH DEPT. <u>JAN 26 1970</u></p>		<p>25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u></p>	
<p>25C. FUNERAL DIRECTOR</p>		<p>ADDRESS</p>	

THE UNIVERSITY OF CHICAGO

PHYSICS DEPARTMENT

1957

APPROXIMATELY

1957

CHICAGO, ILL.

R-163

69 13203

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 13203

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JOSEPH ROBERTS		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year 12 26 69 Hour 7:00 p.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 35 Church Home & Hospital (If not in hospital or institution, give street address or location)		3. DATE PRONOUNCED DEAD Month Day Year December 26, 1969 Hour 7:00 p.m.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 76		10. AGE (In years last birthday) 76	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
15. MOTHER'S MAIDEN NAME		18. INFORMANT ADDRESS	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Fracture of left femur		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street	
22D. TIME OF INJURY (APPROX.) 12 12 69 7:50 p.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Central Ave. from E to W		22F. HOW DID INJURY OCCUR? Pedestrian struck by auto	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12/27/69			
24A. BURIAL CREMATION, REMOVAL (Specify) 2-4-70		24B. DATE 2-4-70	
24C. NAME OF CEMETERY OR CREMATORY UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD		24D. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. FEB 9 1970		25B. NAME OF REGISTRAR Robert E. Selby	

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70-1473

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UNITED STATES DEPARTMENT OF JUSTICE

MEMORANDUM FOR THE ATTORNEY GENERAL

DATE: 10/10/70

FROM: [illegible]

SUBJECT: [illegible]

RE: [illegible]

1. [illegible]

2. [illegible]

3. [illegible]

4. [illegible]

5. [illegible]

6. [illegible]

7. [illegible]

8. [illegible]

9. [illegible]

10. [illegible]

11. [illegible]

12. [illegible]

13. [illegible]

14. [illegible]

15. [illegible]

16. [illegible]

17. [illegible]

18. [illegible]

VALLEY PAPERS CO
RAG CLAREN

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T-460

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) MARY ANN ELIZABETH TAYLOR		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> December 18, 1969		Hour 6:01 A.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 325 S. Fremont		3. DATE PRONOUNCED DEAD Month Day Year December 18, 1969		Hour 6:01 A.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY					
6. SEX Female	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH		10. AGE (In years last birthday) 2		E. STREET AND NUMBER 325 S. Fremont	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS	
19. 795 X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE Sudden death in infancy DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) Yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Minute)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED December 18, 1969					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Cremation		2-26-70		Med. EXAM Bldg.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
FEB 20 1970		Charles S. Springate, M.D.		Med. EXAM. Disposal	
24D. LOCATION (City, town, or county)		24E. LOCATION (State)			
BALTO. MD		BALTO. MD			

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ACADEMY BOND

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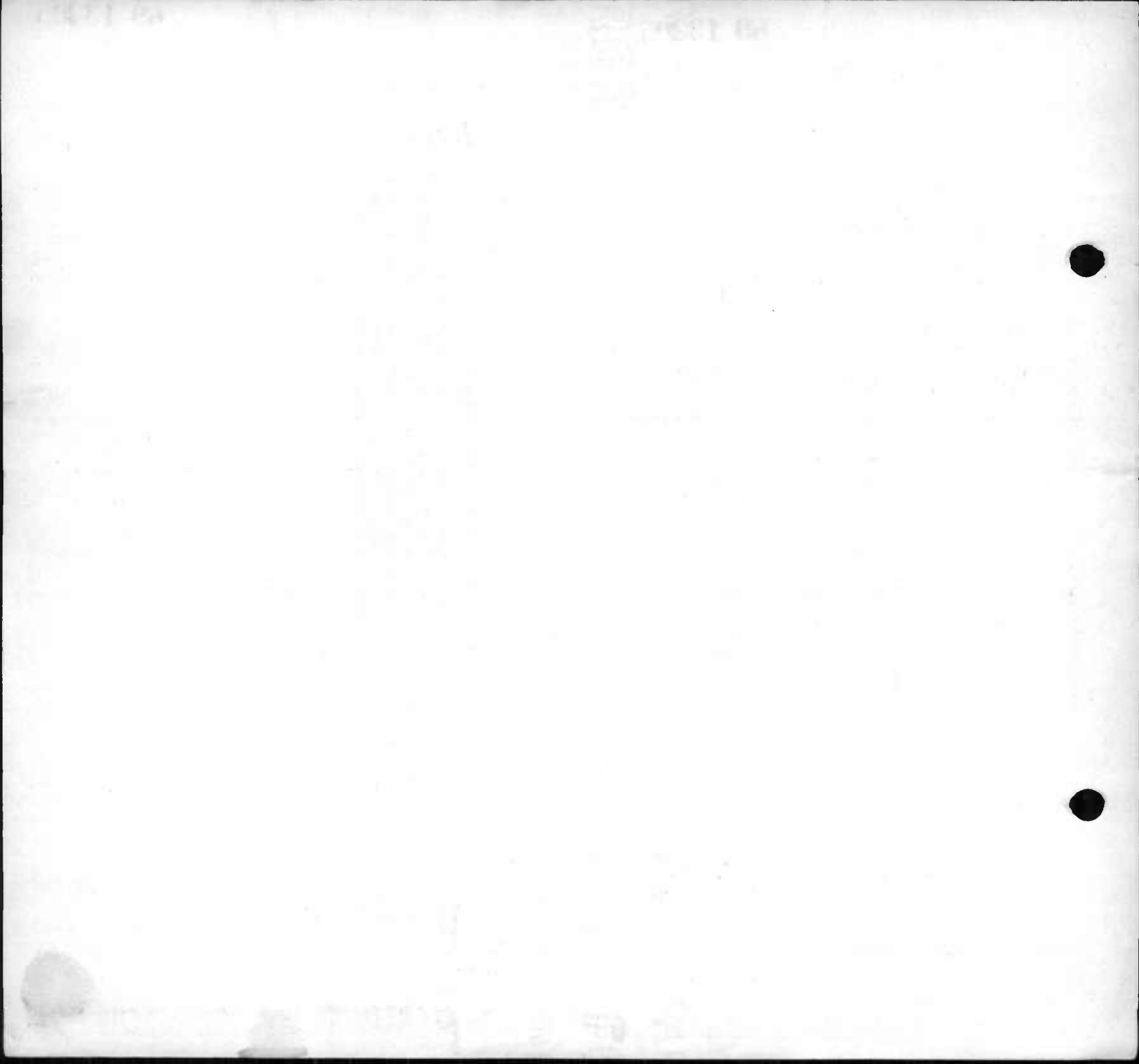
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 13205
CERTIFICATE OF DEATH				
BIRTH NO. D-250 69 13205		2. DATE AND HOUR OF DEATH 12/10/69 6:45 p. M.		
1. NAME OF DECEASED (Type or Print) Baby girl Dixon		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 2841		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL OF BALTIMORE, INC. 42		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4516 PENNACOST AVE		
5. SEX F	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/10/69	
9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country)	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME SPENCER DIXON		14. MOTHER'S MAIDEN NAME MARY LOVE		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS Dr. SRABSTEIN JORGE SINAI HOSPITAL	
18. 776.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: PRIMARY APNEA (B) PREMATURITY (C) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30'		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE 		23B. DATE SIGNED 12/10/69		
23C. PHYSICIAN'S NAME (Type) SRABSTEIN, JORGE		23D. ADDRESS ANATOMY BOARD OF MARYLAND BALTIMORE		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 2-26-70		
24C. NAME OF CEMETERY		24D. LOCATION (City, town, or county) (State)		
25A. DATE REC'D BY HEALTH DEPT. MAR 2 1970		25B. NAME OF REGISTRAR Robert E. Taylor		
25C. FUNERAL DIRECTOR		ADDRESS		
MORTUARY SERVICE - BCHO				



F-148

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 13206

BIRTH NO.

69-18766

1. NAME OF DECEASED (Type or Print) BABY BOY FAUBLE		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 JOHNS HOPKINS HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year Hour October 5, 1969 2:28A.M.	
6. SEX Male		7. RACE Cauc	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 202	
9. DATE OF BIRTH Oct. 5, 1969		10. AGE (In years last birthday) 2 37	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. STREET AND NUMBER 1748 E. Lombard Street	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 7613 I Immaturity due to premature rupture of membranes as a result of maternal abdominal trauma		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMATURE RUPTURE DUE TO, OR AS A CONSEQUENCE OF: of membranes as a result of maternal abdominal trauma	
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No)			
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1700 Gough Street		22D. TIME (Month) (Day) (Year) (Hour) (Minute) OF INJURY (APPROX.) Sept. 27, 1969 10:05	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? assaulted on street	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Russell S. Fisher, M.D. M.D. EXAMINER'S NAME (Type) DATE SIGNED 10-7-69			
24A. BURIAL CREMATION, REMOVAL (Specify) Cremated		24B. DATE 2-24-70	
24C. NAME of CEMETERY or CREMATORY Medical EXAMINERS		24D. LOCATION (City, town, or county) (State) Ba/to. Md.	
25A. DATE REC'D BY HEALTH DEPT. MAR 4 1970		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR ADDRESS		25D. HOSPITAL DISPOSAL	

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/68

HOSPITAL DISPOSAL

